NORTHWEST
Family Practice

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Controlled Medication Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.

_____ It is unrealistic to expect pain medicine to completely relieve all discomfort. Your provider hopes to reduce your pain so that you can regain function. Realistic pain reduction with long term opioid use is expected to be about 30 percent.

_____ I understand that if I break this agreement, my provider will stop prescribing these pain-control medicines. My provider may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal/illicit substances. This includes others' prescription medications.

_____ I will not share, sell or trade my medications with anyone, including family members.

_____ **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider. This includes the Emergency Department and Urgent Care.**

_____ In the event of an emergency I will communicate to any other emergent/urgent provider that I am under a Pain Agreement with my Primary Care Provider.

_____ I will safeguard my pain medicine from children, loss or theft. **Lost or stolen medicines will not be replaced.**

_____ I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or during regular office hours.

_____ I agree to use _____ Pharmacy,

Located at _____

Telephone number, for filling prescriptions for all pain medications: _____

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_____ I authorize my provider and pharmacy to cooperate fully with any city, state, or federal law enforcement agency. If I sell my narcotics my name will be referred to the DSHS Fraud Unit. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medicine.

_____ I am expected to be an active participant in alternative treatments to help reduce my pain. Treatments, consultations or studies (IE: EKG, labs, physical therapy, X-rays, etc.) may be required that I may have to pay for.

_____ I agree that I will use my medicine at a rate no greater than prescribed.

_____ **I will bring all medicine to every office visit.**

_____ I understand that if treatment fails to demonstrate a significant improvement in pain levels, functional status or quality of life, or if at any point the risk of pain medication outweighs the benefit, these treatments will be discontinued.

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement has been entered into on:

Date: _____

Patient Signature: _____