Sample Prescriber/Patient Opioid Treatment Agreement

For the Prescriber:

I have or will be prescribing opioid medication(s) to _____to treat his/her pain condition. I agree to the following:

1. I will carefully assess the patient and provide what I believe to be the best treatment for his/her pain condition.

2. I will regularly review the patient's condition and make adjustments to his/her treatment as necessary.

3. I will register this agreement with the Prescription Monitoring Program which will provide notification should the above named patient receive other monitored drugs from an unauthorized prescriber and/or pharmacy.

4. I will be readily available to answer any of the patient's questions regarding this treatment.

For the Patient:

I understand that I am receiving prescribed opioids from _____ to treat my condition. I agree to the following:

1. I will not seek opioids from another prescriber. Only _____ will prescribe opioids for me.

2. I will not take opioids in larger amounts or more frequently than is prescribed by _____.

3. I will not give or sell my medication to anyone else, including family members; nor will I accept any medications from anyone else.

4. I will not use over-the-counter opioid medications such as 222's and Tylenol® No. 1 without first discussing this with Dr. _____.

5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication, or take more than prescribed), _____ will not normally prescribe extra medications for me; I will have to wait until the next prescription is due.

6. I will fill my prescriptions at one pharmacy of my choice. This is my pharmacy's name, address, and phone number:

_____

7. I will store my medication in a secured location to limit the potential of unsafe use of the medication by others

8. If requested by my physician, I will complete periodic urine drug screening to assist in verifying compliance with my treatment plan.

9. If requested by my physician, I will present my medications to my pharmacy or physician's office to verify that the correct quantities are in my possession.

I understand that if I break these conditions my prescriber _____ may choose to cease writing monitored drug prescriptions for me.

Patient Name (Please Print): _____

Patient Signature: _____

Patient's NS Health Card Number: _____

Prescriber Name (Please Print): _____

Prescriber Signature: _____

Date: _____