Appendix A

Sample Patient Agreement for Long-term Opioid Therapy

1.	I, agree that Dr will be the <u>only physician</u> prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at <u>one pharmacy</u> . The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.
2.	I will take the medication <u>at the dose and frequency prescribed</u> by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.
3.	I will <u>attend</u> all reasonable appointments, treatments and consultations as requested by my physician. I agree to <u>other pain consultations/management strategies</u> as necessary.
4.	I understand that the common <u>side effects</u> of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to <u>refrain from driving a motor vehicle</u> or operating dangerous machinery until such drowsiness disappears.
5.	I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of <u>opioid withdrawal</u> . I understand that opioid withdrawal is uncomfortable but not life threatening.
6.	I understand that there is a <u>small risk</u> that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.
7.	I understand that the use of a <u>mood-modifying substance</u> , such as tranquilizers, sleeping pills alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
8.	I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.
9.	I agree to be responsible for the <u>secure storage</u> of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.
10.	I consent to <u>open communication</u> between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.

11. I understand that if I break this agreement, my physician reserves the right to stop prescribing

opioid medications for me.