Opioid Pain Care Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for post-surgery pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines.

1. I agree to inform Drs. Strull and Strull if I am under pain management treatment from other doctors.

2. I understand that the common adverse effects of opioid or pain medicine therapy include but are not limited to: upset stomach, nausea, or vomiting, sleepiness or drowsiness, disorientation, problems with coordination, balance or reflexes, sweating, itching or allergic reaction, constipation, and inability to drive or operate machinery. I agree not to drive a vehicle or operate equipment while I am taking this medication. This is not a comprehensive list; you should read the pharmacy information with your prescription. If you have questions, do not hesitate to ask.

3. I will not give or sell my medication to anyone else, including family members; nor will I accept any medication from anyone else. I agree to be responsible for the secure storage and disposal of any medications at all times and make sure that I trust the person getting me home from my appointment to handle my medications. Lost or stolen medicines will not be replaced.

4. I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. I agree to notify my provider of the use of all substances, legal or illegal, including marijuana, alcohol, and medication not prescribed to me.

5. I understand that I may become physically dependent on opioid or pain medications, which in a small number of patients may lead to addiction. I agree that if necessary I will permit referral to addiction specialist.

6. I understand that narcotic use during pregnancy may have an effect on the unborn baby. Please contact your obstetrician prior to use.

7. I hereby agree that my provider has the authority to discuss my pain management with other healthcare professionals and my family members when deemed medically necessary in the provider's judgment.

8. My provider may obtain information from state controlled substances database, KASPER, INSPECT, and/or other prescription monitoring programs.

9. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

10. 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 will be given to me upon my request.

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Patient's (or Legal Guardian's) Name and Signature Date

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Witness' Signature Date

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Doctor's Signature Date