Opioid Medication Treatment Agreement

I understand that I am receiving opioid medication from Dr. _____ to treat my pain condition. I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. _____ will prescribe opioids for me.

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

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

4. I will not use over-the-counter opioid medications such as 222's and Tylenol® No. 1.

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), Dr. _____ will not 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; pharmacy name:

   _____

7. I will store my medication in a secured location.

I understand that if I break these conditions, Dr. _____ may choose to cease writing opioid prescriptions for me.

_____ _____

Prescriber signature Date

_____ _____

Patient signature Date

_____

Patient name (print)

— Source: Modified from Kahan 2006; Appendix to Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain