Pain Management Agreement

Narcotic pain medicine is not the only way to reduce chronic pain. Other treatments in a comprehensive chronic pain management plan might include non-narcotic pain medicine, physical and occupational therapy, psychological counseling, exercise, smoking cessation, vocational counseling and other treatments. As part of your pain management plan, your doctor thinks a **trial** of narcotic pain medicine might decrease your pain and improve your functionality. Narcotic pain medicine has the potential for abuse and can be dangerous if it is not used as prescribed. In order for you to continue your trial of narcotic pain medicine, you must comply with the pain management rules set out below. If you break these rules, your doctor will stop prescribing narcotic pain medicine for you.

I understand that it is my responsibility to comply with the following rules:

1. I will take my medicine as my doctor prescribed it. I will tell my doctor about all the medicine I am taking.
2. I will make sure this office has my most current telephone number.
3. I will not ask for any pain medicine from doctors who are not with this office. If I have an emergency and need treatment with pain medicine, I will tell the doctor about this agreement and that I can only have a 3-day prescription. I will have them send a copy of my medical records from the visit to this office.
4. Refills for pain medicine will only be made during my office visit or regular office hours. No refills will be made during evenings or weekends.
5. I will keep my appointments. I will bring all my medicine – in the original bottles – to every appointment.
6. I will come to the office on days I do not have a scheduled appointment for a pill count when asked.
7. I will protect my medicine from loss or theft. Lost prescriptions and medicine will not be replaced.
8. I will not share, sell or trade my medicine with anyone.
9. I will not use alcohol or illegal street drugs, and I will actively participate in any drug-dependence program recommended.
10. I consent to, and will take, random drug screenings to see if I am following these rules.
11. I will actively participate in return-to-work efforts and programs designed to improve function.
12. I will actively participate in psychiatric or psychological assessments, as needed.
13. I will only use the pharmacy I have listed below to fill my pain medicine prescriptions. I give my permission for my doctors and my pharmacy to cooperate fully with any investigation into possible misuse, sale or other diversion of my pain medicine.

    Pharmacy name: _____

    Address: _____

    Phone number: _____

All of my questions and about my treatment and these rules have been answered. A copy of this document has been given to me.

Patient's Signature	Date/Time	Witness Signature	Date/Time
Signature of Authorized Person	Date/Time	Relationship to Patient	
Healthcare Provider Signature	Date/Time		

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH

Pain Management Agreement

Name / MR # / Label