Reasons for being careful when taking this medicine have been explained to me. I understand:

- I should not drink alcohol while I take any drug listed above. I put myself in danger when I do this.
- I should avoid driving or using machines while taking this medicine. If I am required to drive or use machines, I must be very careful. Pain medicine can affect the way I think and how I react to changes around me.
- I should not take over-the-counter medicine or products made with herbs. They may combine with drug(s) listed above in harmful ways.
- Pain medicine side effects include but are not limited to:
  - Constipation
  - Nausea and/or vomiting
  - Having trouble passing urine
  - Heart rhythms that are not normal
  - Depression
  - Problems having sex
  - Pain gets worse when long-term use makes medicine less effective (opioid-induced hyperalgesia)
  - Your body depends on this medicine so much that you get sick when you stop taking it (physical dependence). This does not mean you are addicted to the medicine.

I am responsible for knowing and doing all of these things:

- Only the provider listed above prescribes my pain medicine. He or she will choose some other provider to prescribe my refill in his or her absence.
- I will tell my provider within 72 hours of any sudden need for surgery or emergency care. My provider may decide whether my need for this drug or one like it was in fact an emergency.
- I will keep all office visits scheduled with my provider and any other staff member my doctor asks me to see. This includes registered nurses and Behavioral Health staff.
- I will comply with all treatments my provider orders. This includes physical therapy.
- I will come in for random pill counts within 24 hours of being asked.
- I will not hold my prescribing provider liable if I am involved in an accident while taking the medicine(s) listed above.
- I will provide samples of breath, urine, blood, hair or saliva for drug screening. Requests will be random and without warning.
- My paper prescription(s) and/or drug(s) will be kept safe and secure in a place only I have access to. This place will protect these items from being destroyed, lost, stolen, damaged by water or spilled in a sink or toilet.
  - No paper prescription for any drug listed above will be replaced if the paper is lost, stolen, damaged or destroyed.
  - If I lose or damage any drug container or its contents, I will not be given a new paper prescription.
- I will not allow friends or family members to use the drug(s) prescribed for me.
- I will not hoard, share, sell or use this drug in any way that breaks local, state, or federal law.
- I will report stolen medicine to the police and give a copy of the report to my provider. I will report
Patient Name: _____________________________

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CHRONIC PAIN MANAGEMENT AGREEMENT

medicine destroyed or damaged by fire to the fire department. I will give a copy of the report or the damaged drug(s) to my provider.

- I will inform my provider of all medicine I take. This includes over-the-counter and herbal products. I will see or consult my doctor any time I want to take something new for any reason.
- If asked by a provider, I will sign a release of information for mental health records kept here or any other place I have received care for pain, opioid use and/or substance abuse.
- When I need a refill, I will call my provider at least three working days before the refill is due.
  - Failure to request in advance may mean I will not receive my prescription when I am due for refill.
  - Friday requests for refills may not be granted.
- If I will be out of town, my doctor may give me a prescription that can be filled on a stated date.
- I will practice mental coping techniques shown to me by staff members who assist in my care and treatment.
- My provider decides when and whether the dose of any listed medicine should be changed. I will not change the dose without his or her knowledge and consent.
- I accept that my pain might not respond to the drug(s) prescribed for me. I do not expect to be free of pain. I understand there is some risk that I may become addicted to the drug(s) I take.
- I understand my provider may no longer prescribe this/these drug(s) or others if:
  - I do not get enough pain relief to carry on my normal routine of work, rest and other activities.
  - Side effects persist.
  - Treatment goals cannot be achieved through use of a prescribed drug.
  - There is a problem with taking higher doses.
  - I fail to comply with all terms of this signed treatment agreement.

Failure of Chronic Pain Management Agreement
The provider listed above may decide I have failed to fulfill this agreement if one or more of these occur:

- I miss two or more scheduled visits.
- I cancel a visit on the day it is scheduled more than two times.
- A urine drug screen sample contains:
  - An opioid my doctor did not prescribe
  - An illegal substance
- A urine drug screen sample does not contain the drug(s) he or she prescribed for me.
- I refuse a urine drug screen or random pill count.
- I am charged with a crime.
- I am jailed for actions that involve any controlled substance.
- I upset or threaten staff with my words or actions on the phone or in person.
- Any other condition my provider has chosen to impose.

Failing this Chronic Pain Management Agreement means:

- My provider may continue to provide other medical care I need.
- He or she will no longer prescribe any medicine(s) listed above.
- He or she will not prescribe any other controlled substance whether or not it is listed in this agreement.
- Other Gundersen Health System providers may choose not to prescribe opioids and/or other controlled substances not listed in this agreement.
My provider may refer me for substance abuse evaluation.

My acceptable pain level or range is ___________ based on the 0 to 10 scale explained to me by my provider or nursing staff.

The only pharmacy I will use to fill prescriptions for drug(s) listed in this agreement is:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

A photo ID is required for prescription pick up. I can authorize one person other than myself to pick up my paper prescription for me. This person is also required to provide photo ID. This person is:

__________________________________________________________________________________________

My goals for improved function are:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

When I sign this agreement, I accept all these rules and conditions. I understand that if I do not follow these rules, my provider may decide I have failed the agreement.

I have read and have had explained to me Opioids: Safe Use and Side Effects. I understand what it means. I have read this entire agreement. It has been explained to me. All of my questions have been answered. I fully understand what I am signing. I agree to all rules and conditions listed in this agreement. I am not under the influence of any substance that might affect my judgment. I permit my provider to share protected health information. He or she may coordinate my care with other providers. I authorize Gundersen Health System to release a copy of this 3-page agreement to the pharmacy listed above. I have received a copy of this agreement.

Patient Signature: ________________________________ Date: ________________

Witness Signature: ________________________________ Date: ________________