Practice Name
Practice address

Date effective:

Review date:

PATIENT AGREEMENT FOR DRUGS OF DEPENDENCE THERAPY

The purpose of this agreement is to give you information about the medications you will be taking for pain and/or mental health management at this practice, and to ensure that you and your doctor comply with all state, territory and Federal regulations concerning the prescribing of drugs of dependence.

The doctor's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the patient–doctor relationship and full agreement and understanding of the risks and benefits of using potentially addictive drugs to manage your condition.

A trial of long-term opioid therapy may be considered for moderate to severe pain with the intent of reducing pain and increasing function. A trial of long-term benzodiazepine therapy may be considered in very limited circumstances if other options have failed or are considered inappropriate.

In signing this agreement, you have agreed to a trial of long-term use of potentially addictive medications as part of your treatment. These drugs of dependence can be very useful, but have a high potential for misuse and are therefore closely controlled by state, territory and Federal governments. Because your doctor is prescribing such medication to help manage your condition, it is considered good practice to agree to the conditions outlined below.

My responsibilities as a patient

I agree to see one doctor at one practice for all my health needs and prescriptions. ☐
My Doctor will be Dr _____

Prescriptions can be written for a maximum of 1 month supply and will be filled at the same pharmacy. Pharmacy: _____ ☐
Phone number: _____

It is my responsibility to schedule appointments for the next prescription before I leave the clinic or within 3 days of the last clinic visit. ☐

I accept that set monthly appointments must be made to review ongoing therapy. No walk-in appointments for medication refills will be granted. ☐

I am responsible for my prescriptions. I understand that lost prescriptions will not be replaced. ☐

I understand that prescriptions will not be mailed or obtained by the phone if I am unable to obtain my prescriptions monthly. ☐

I agree that this medication is prescribed as a trial. If it appears that it is not effective it may be discontinued. ☐

I will inform my doctor of all medications I am taking, including herbal remedies and illicit medication. ☐

I will communicate with my doctor my pain level and functional activity along with any side effects of the medications. This information allows my doctor to adjust my treatment plan accordingly. ☐

I will not request or accept drugs of dependence from any other doctor or individual while I am receiving such medication from my doctor at XXXX Practice ☐

I understand the use of alcohol together with drugs of dependence is contraindicated. ☐

I will not use any illicit substances, use of these substances may result in a change to my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the patient–doctor relationship. ☐

If I have a history of alcohol or drug misuse/addiction, I must notify my doctor of such history since treatment with drugs of dependence may increase the possibility of relapse. ☐

I agree and understand that my doctor reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the patient–doctor relationship. ☐

The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the patient–doctor relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. ☐

Taking my medications

I understand that the medication is strictly for my own use. ☐

I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. ☐

I am responsible for taking my medications as directed. I agree to take the medication only as prescribed. ☐

Any evidence of drug hoarding, acquisition of any opioid medication or additional analgesia from other doctors (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the patient–doctor relationship. ☐

I understand that while physical dependence is to be expected after long-term use of opioids, any signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids. ☐

My behaviour

I understand that there is a wide spectrum of drug misuse behaviours, including those documented below. I understand that cessation of the medication trial, or cessation of the patient–doctor relationship may occur if I display any of the following behaviours: ☐

- presenting to the clinic intoxicated, as assessed by clinical staff
- making any physical threat to any member of staff or to other patients
- aggressively complaining about a need for medication
- persistently requesting to have my medication dose increased despite clinical advice
- taking a few extra, unauthorised doses on occasion
- visiting multiple doctors for controlled substances (doctor shopping)
- hoarding medication
- using a controlled substance for non-pain relief purposes (eg to enhance mood, sleep aid)
- starting frequent unscheduled clinic visits for early refills
- using consistently disruptive behaviour when arriving at the clinic
- obtaining drugs of dependence from family members (including stealing from older relatives)
- having a pattern of lost or stolen prescriptions
- displaying anger or irritability when questioned closely about pain
- being unwilling to consider other medications or non-pharmacologic treatments
- escalating my dose without authorisation
- testing positive for a non-prescribed drug(s) or illicit drug(s) in my urine
- injecting an oral formulation
- forging prescriptions

- selling medications
- refusing diagnostic workup or investigation
- obtaining controlled substance analgesics from illicit sources.

I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient's signature _____

Date_____

Doctor's signature_____

Date_____