PATIENT TREATMENT AGREEMENT FOR SAFE AND EFFECTIVE USE OF OPIOIDS FOR CHRONIC NON-CANCER PAIN

I _____ agree that Dr. _____ will be the only physician prescribing medications for me. I will get all my prescriptions at the same pharmacy. My pharmacy is _____.

Dr. _____ will be prescribing generic brands.

I am not on the methadone program. If I am on methadone my doctor for methadone is Dr. _____. I get my methadone at _____ pharmacy. I understand that if I am on the methadone program Dr. _____ will need written permission from my methadone doctor to give me any medications such as sleeping pills, anxiety drugs or gabapentin. I will get all my prescriptions filled at my methadone pharmacy.

I will NOT request early refills. I will take responsibility for ensuring that my medication is not lost or stolen. In the event that this happens I will not request an early refill.

I understand that these medications may impair my ability to drive or to operate machinery. I will not do these things unless I can do it safely.

I understand that these medications may be addictive. I agree to undergo blood, urine or hair testing as requested by Dr. _____. If I become addicted I will agree to addictions treatment.

I will not use illegal drugs. I will agree to blood, urine or hair testing if requested by Dr. _____.

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

I understand that I should check with Dr. _____ or my pharmacist before taking any other non-prescription or herbal products such as Benylin DM, Sudafed, acetaminophen with codeine and gravol.

I agree that Dr. _____ can talk to my pharmacist and other physicians without my specific consent if he/she feels it is necessary.

If I break any of the conditions of this contract, Dr. _____ can stop prescribing medications for me and the pharmacist can request that I do not use their pharmacy.

I agree that Dr. _____ has permission to view on PIP all drugs that have been prescribed for me regardless of whether my profile has been masked or not.

Date: _____

_____	_____	_____
Patient Signature	Doctor Signature	Pharmacist Signature

HSN: _____

- Adapted from the Canadian Guideline for Safe and Effective Use of Opioids in Chronic Non-Cancer Pain