

## **Patient Contract for Pain Management and Medication Agreement**

**(Do not fill if you are not requesting opioids)**

This agreement between «FirstName» «LastName» (the patient) and Orion Spine and Pain (OSP) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient is to receive pain management and/or pain medications. This may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, and biofeedback), alternative therapies, physical therapy, weight management and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. Pain medication may not eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.
2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed to me. Prescriptions and bottle of medications must be safeguarded from loss and out of reach of children.
3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on opioids and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant, and I will use appropriate contraceptive measures during treatment with medications. Many medications could harm the fetus or cause birth defects.
5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.
6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-28 hours of the last dose.
7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.
8. I agree that continued treatment and/or refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.
9. I am responsible for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances, as determined by and at the Physician's discretion and will only be bridged until the next available appointment.
  - A. Refill requests for medications requiring a written prescription must be called to the office 48 hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered in any other manner.
  - B. Refills will not be made after hours, at night or on weekends. This policy will be strictly adhered to.
  - C. Refills will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
  - D. Refills will not be made as an "emergency". I will call my pharmacy at least 4-5 days prior to needing my prescription(s) (for medications that do not require a written prescription).
10. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my physician.

11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.
12. I will not share, sell or trade my medication or exchange medication for money, goods or services.
13. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.
14. I understand that changing dates, quantity or strength of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.
15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.
16. I agree that I will submit to random urine, blood, or saliva toxicology tests, if requested, to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.
17. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.
18. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued, and my care referred back to my primary care physician.
19. I will keep all scheduled follow-up appointments as outlined in my treatment plan.
20. I understand that the main treatment goal using pain medications is to improve my ability to function and/or work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.
21. I understand with respect to the prescribing of my pain medications the doctors, my pharmacy, and insurers will cooperate fully with any city, state or federal agency in the investigation of any possible misuse, sale or other diversion of my pain medication as required by law, state and federal regulations.
22. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my



permission to allow sharing of medical history in regards to medication use with other health care agencies.

23. I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology and/or psychological and detoxification if indicated. Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis. Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement.

I agree to use \_\_\_\_\_ Pharmacy, located at \_\_\_\_\_, telephone number \_\_\_\_\_, for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

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**Patient's Printed Name**

**Date of Birth(MM/DD/YYYY)**

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**Signature of Patient(or Legal Representative for Patient)**

**Date**

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**Legal Representative**

**Relationship**

If at any time you are concerned about your medication or side effects of your medication, you may call us at XXXXXXXXX.

## Opioid Risk Tool (ORT)

☐ Check here if you DO NOT currently take or wish to take opioids. In this case you may skip this questionnaire.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

**Instructions:** Check the box next to each applicable answer. Each selection is assigned a score.

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
<input type="checkbox"/> Alcohol	1	3
<input type="checkbox"/> Illegal drugs	2	3
<input type="checkbox"/> Rx drugs	4	4
<b>Personal history of substance abuse</b>		
<input type="checkbox"/> Alcohol	3	3
<input type="checkbox"/> Illegal drugs	4	4
<input type="checkbox"/> Rx drugs	5	5
<input type="checkbox"/> Age between 16—45 years	1	1
<input type="checkbox"/> History of preadolescent sexual abuse	3	0
<b>Psychological disease</b>		
<input type="checkbox"/> ADD, OCD, bipolar, schizophrenia	2	2
<input type="checkbox"/> Depression	1	1
<b>Scoring totals</b>		

Total Score: \_\_\_\_\_

Scoring Interpretation: \_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_

Date: \_\_\_\_\_

## SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN—SOAPP®-R)

☐ Check here if you DO NOT currently take or wish to take opioids. In this case you may skip this questionnaire

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Score: \_\_\_\_\_

Scoring Interpretation: \_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_

Date: \_\_\_\_\_