Model patient/provider contract for long-term treatment with opioid medication*

Names of patient and health care provider

This is a contract between _____ (print or type patient's name) and _____ (print or type health care provider's name), who is called "my health care provider" in this contract.

Reason for this contract

Opioids (sometimes also called narcotics) are drugs that have a potential for abuse and addiction. I understand this contract is essential to the trust and confidence needed in a patient and health care provider relationship and that my health care provider's willingness to treat me is based on my compliance with the terms of this contract.

Agreement to comply

In order to receive treatment with opioid medication from my health care provider (named above) I agree to comply with this contract. I understand my health care provider may terminate treatment with opioid medication at any time he or she believes I am not complying with the terms of this contract.

Risks, side effects and benefits of opioid medication

I understand the opioid medication is being prescribed to help me manage chronic pain that has not responded to other treatments. I am aware that use of this medication has certain risks associated with it such as sleepiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowed reflexes, slowed breathing rate, sleep apnea, physical dependence, tolerance and addiction. The risks, side effects and benefits have been explained to me. My health care provider has discussed with me:

- that this medication may affect my ability to safely operate a vehicle;
- the problems that may occur if I drink alcohol while taking this medication;
- (for female patients) the problems that might occur if I become pregnant while taking this medication; and
- that there may be other risks and side effects if I take this medication while also taking other medications (for example, there is a significant increased risk of sedation, overdose and other serious problems if I take benzodiazepines (Valium, Ativan, Xanax, Klonopin, etc.) while taking this medication).

Goal of treatment and risk of addiction

The medication must be both safe and effective. I understand there is a risk that this medication may become addictive. The goal is to use the lowest dose that is both safe and effective to help me function better. If my activity level or general function gets worse, the medication may be changed or discontinued. My health care provider must provide written reports of work ability when required by workers' compensation rules.

Participation in other types of treatment

I will fully comply with other treatment recommendations and specialist consultations recommended by my health care provider. This might include a referral to a pain medicine specialist.

Keeping scheduled appointments

I agree to keep regularly scheduled appointments with my health care provider and participate as requested in the evaluation of the effectiveness of this treatment.

Only one health care provider to manage medication

All opioid and other controlled drugs for pain will be prescribed only by my health care provider. When he or she is not available, my medication will be prescribed or managed by _____ (name of other health care provider).

- I will not obtain opioids or other controlled drugs from other health care providers, unless I have another condition that requires the prescription of a controlled drug (narcotics, tranquilizers, barbiturates or stimulants) or if I am hospitalized for any reason. In either of these situations, before opioids or other controlled drugs are prescribed or dispensed by another health care provider, I agree to tell the other provider that I am being treated with long-term opioids for chronic pain unless I am incapacitated from doing so.

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- I will keep my health care provider (or my provider's clinic) informed about any new medical conditions that develop and other medications I am taking.
- I understand I should check with my health care provider or my pharmacist before taking any other medications, including over-the-counter medications.
- My health care provider agrees to be available or provide coverage for breakthrough pain or episodic pain not responsive to the planned treatments.

Taking medication exactly as prescribed

I will take my opioid medication exactly as prescribed and will not change the medication dosage or schedule without my health care provider's approval. I understand that if I stop taking this medication without my health care provider's supervision, it may cause symptoms of withdrawal.

Refills

I am responsible for keeping track of my opioid medication and planning ahead to arrange refills in a timely manner so I will not run out of medication. I understand I will be given enough medication to last for a fixed amount of time when used as prescribed. Refills will only be given during regular office hours. Refills will not be made at night, on weekends or on holidays. Prescriptions cannot be filled early.

Lost or stolen prescriptions or medications

If my opioid prescriptions or medications are lost or stolen, they may not be replaced. I understand my health care provider is only allowed to replace a lost or stolen prescription once.

Access to medication by others prohibited

I will not give, share or sell my opioid medication to anyone.

Monitoring by health care provider

- I agree that my health care provider may contact any other providers with whom I am treated to discuss my use of opioid medication.
- I agree that my health care provider will periodically access the Minnesota Prescription Monitoring Program database to review my prescription history.
- I agree to abstain from all illegal drugs and will provide urine specimens at my health care provider's request to monitor my compliance with treatment.

Discontinuance of opioid medication

I understand that if my opioid medication is stopped for any reason, my health care provider will taper me off the medication in a controlled fashion to avoid withdrawal symptoms and will offer alternative ways of treating my condition or referral to another provider.

_____ Date signed: _____

Patient signature

_____ Date signed: _____

Health care provider signature

*This model contract form is authorized by the commissioner of the Minnesota Department of Labor and Industry pursuant to Minnesota Rules 5221.6110, subp. 7. The health care provider and patient are not required to use this model contract to comply with the contract requirements of that rule. However, if this model contract is used, it is deemed to meet the requirements of the rule once completed and made a part of the patient's medical record. The patient and health care provider are encouraged to talk about each of the agreements before signing this contract.