Treatment contract for opioid use in the management of chronic pain

Patient's name: _____ Date of birth: _____

Address: _____

_____

Medical practitioner's name: _____

PLEASE REVIEW ALL CONDITIONS BEFORE SIGNING

I, _____ , understand that I am being prescribed an opioid medicine in an attempt to reduce my pain and improve my level of functioning. My medical practitioner (doctor) and I have discussed that opioids can help contribute to achieving these goals for some patients, however, for others they may not be helpful at all. I understand that an opioid medicine is only one component of my plan for managing chronic pain.

My doctor and I have discussed and jointly agree to the following conditions:

1. My doctor is responsible for prescribing a safe and effective dose of an opioid medicine. I will not use an opioid other than at the dose prescribed and I will discuss any changes in my dose with my doctor.
2. I will only obtain my opioid medicine using a prescription from the doctor who signs this contract, or from other doctors in the same practice authorised to prescribe to me. I understand that no early prescriptions will be provided.
3. I am responsible for the security of my opioid medicine. I acknowledge that lost, misplaced or stolen medicines or prescriptions for opioids will not be replaced.
4. While most people do not have serious problems with this type of medicine when used as directed, there can be some adverse effects. My doctor has explained to me the main potential adverse effects and I will inform them if I experience any unexpected problems or concerning effects.
5. I acknowledge that possible dependence is an important consideration when deciding if an opioid medicine should be used for pain management, and I have informed my doctor of any present/past:
   - Dependence on alcohol or drugs
   - Illegal activity related to any drugs (including prescription medicines)
6. I am aware that providing my opioid medicine to other people is illegal and could endanger them
7. I am personally responsible for making sure I am fit to drive or operate heavy machinery while taking an opioid. I will not do these activities at times when the opioid dose is being increased or if I feel cognitively impaired.
8. My doctor respects my right to participate in decisions about my own pain management and will explain the risks, benefits and adverse effects of any treatment
9. My doctor and I will work together to reduce my pain and improve my level of functioning
10. I understand and accept that my doctor may stop prescribing my opioid medicine or change the treatment plan if my level of activity has not improved, if I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above

Patient's signature: _____ Date: _____

Medical practitioner's signature: _____ Date: _____

bpac nz
better medicine

PLEASE PROVIDE A COPY OF THE SIGNED CONTRACT TO THE PATIENT

Adapted from: Prescribing drugs of dependence in general practice, Part C1. Opioids. Appendix B2. Drugs of dependence treatment agreement/contract. The Royal Australian College of General Practitioners. 2017. Available at: **www.racgp.org.au/download/Documents/Guidelines/Opioid/addictive-drugs-guide-c1.pdf** (Accessed Dec, 2022)