

Rev Sept 2008

**Chronic Pain Contract**

Regional Medical Center at Memphis

I, \_\_\_\_\_ (*patient receiving chronic pain medications*), have agreed to use pain medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day. I understand the following guidelines for continuing chronic pain treatment under the care of (*physician prescribing chronic pain medications*) \_\_\_\_\_.

- 1. I understand that I have the following responsibilities:
  - a. I will take medications at the dose and frequency prescribed.
  - b. I will not increase or change how I take my medications without the approval of this physician.
  - c. I will not ask for refills earlier than agreed. I will arrange for refills at the prescribed interval **ONLY during regular office hours**. This includes after-hours, on holidays, or on weekends.
  - d. I will obtain all pain medications only at one pharmacy. I will inform my physician if I change pharmacies.

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

- e. I will authorize my physician to provide a copy of this contract to my pharmacy.
- f. I will not request any pain medications or controlled substances from other providers and will inform this physician of all other medications I am taking. I understand that other physicians should not change doses of my pain medications and I will notify my physician of any changes to my pain medications made by another provider.

I agree to use only the following providers. I will notify my physician of any changes in my health care and / or changes in my providers.

Provider: _____	Clinic: _____	Phone Number: _____
Provider: _____	Clinic: _____	Phone Number: _____
Provider: _____	Clinic: _____	Phone Number: _____
Provider: _____	Clinic: _____	Phone Number: _____

- g. I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.
- h. I will allow my physician to discuss all diagnostic and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of maintaining accountability.
- i. I will inform my physician of any new medications or medical conditions.
- j. I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
- k. I will keep medications only for my own use and will not share them others. I will keep all medications away from children.
- l. I will bring all medications (including those prescribed by other health care providers) in the original prescription bottle to all appointments.
- m. I will participate in any medical, psychological, or psychiatric assessments recommended by my physician.
- n. I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use street drugs (including marijuana, cocaine, etc) or another person's prescription (including my immediate family's prescriptions). I will inform my physician of alcohol and/or drug use, past or present, as well as any history of alcoholism/addiction.
  - a. I will actively participate in any treatment program for drug and alcohol addictions if my physician asks me to enter such a program. Programs may include:
    - 12-step program and securing a sponsor
    - Individual counseling
    - Inpatient or outpatient treatment
    - Other: \_\_\_\_\_
  - b. If I am in a treatment program, I will provide documents from the treatment program to validate my progress and treatment.
3. I consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I am taking.
4. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.
5. **I understand that this physician may STOP prescribing my pain medications if:**
  - a. I do not show any improvement in pain or my activity has not improved.
  - b. I develop rapid tolerance or loss of improvement from the treatment.
  - c. I develop significant side effects from the medication.
  - d. I break any part of the contract outlined above.
  - e. I refuse to consent to a drug screening.
  - f. I fail to comply with other treatments recommended by my providers including, but not limited to, physical therapy, occupational therapy, and psychiatric treatment.
  - g. I miss two consecutively scheduled appointments.
  - h. If my physician determines for any other reason that the pain treatment is not advisable.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this form answered to my satisfaction. I am signing this form voluntarily and I have full right and power to be bound by this agreement.

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Patient's Signature Date

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Provider's Signature Date