

DRAFT PATIENT/PROVIDER CONTRACT
For use with proposed Minn. R. 5221.6105, subp. 7 (J)

Patient/Provider Contract for Long Term Treatment with Opioid Medication

Purpose of this contract and agreement to comply. This is a contract between _____ (name of patient) and _____ (name of health care provider"). Opiates (sometimes also called narcotics) are drugs that have a potential for abuse and addiction. I understand that this contract is essential to the trust and confidence needed in a patient-physician relationship and that my doctor's willingness to treat me is based on my compliance with the terms of this contract. In order to receive treatment with opioid medication from _____, I agree to comply with this contract. I understand that _____ may terminate treatment with opioid medication at any time that he or she believes that I am not complying with the terms of this contract.

Risks, side effects and benefits of opioid medication. I understand that the opioid medication is being prescribed to assist me in managing 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, slowing of reflexes, slowing of breathing rate, sleep apnea, physical dependence, tolerance, and addiction. The risks, side effects, and benefits have been explained to me. _____ has explained to me the problems that may occur if I drink alcohol or become pregnant while taking this medication.

Goal of treatment and risk of addiction. The medication must be both safe and effective. I understand that there is a risk that this medication may become addictive. The goal is to use the lowest dose that is both safe and effective in assisting me to function better. If my activity level or general function gets worse, the medication may be changed or discontinued.

Participation in other types of treatment. I will fully comply with other treatment recommendations and specialist consultations recommended by _____.

Keeping scheduled appointments. I agree to keep regularly scheduled appointments at the clinic and to 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 _____. When _____ is not available, _____ will manage my medications.

- I will not obtain opioids or other controlled drugs from other 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, I agree to tell the health care provider that I am being treated with long term opioids for chronic pain.
- I will keep _____ or the clinic informed about any new medical conditions that develop and all of the medications I receive from other providers.
- _____ agrees to be available or provide coverage for breakthrough pain or episodic pain not responsive to the planned treatments.

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- I understand that I should check with my health care provider or my pharmacist before taking any other medications, including over the counter medications.

Taking medication exactly as prescribed: I will take my medications exactly as prescribed and will not change the medication dosage or schedule without _____'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 medication and planning ahead to arrange refills in a timely manner so that I will not run out of medication. I understand that 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 prescriptions or medications are lost or stolen, they may not be replaced. I understand that my 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 medication to anyone.

Monitoring by health care provider.

- I agree that _____ may contact any other health care provider with whom I treat to discuss my use of opioid medication.
- I agree that _____ 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 the health care provider's request to monitor my compliance with treatment.

Discontinuance of medication. I understand that if my medication is stopped for any reason, _____ 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.

Patient signature

Date signed: _____

Health care provider signature

Date signed: _____