Post Falls Family Medicine, PA

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Pain Management Agreement

Patient:_____ **Physician**:_____

Patient's DOB:_____ **Designated Pharmacy**:_____

1._____ONE prescriber for controlled medications and ONE pharmacy: *I agree to receive pain medications only from my treating physician (name above) or from someone designated by my treating physician. I agree to receive my pain medications only from my designated pharmacy (listed above) unless my treating physician agrees otherwise.*

If you receive controlled medications from another health care professional because of a true emergency, injury or accident requiring urgent care, you agree to tell that practitioner (or have a family member/friend tell that practitioner) about your agreement with this office.

If you receive controlled medications from another health care professional, you agree to call this office within 24 hours and tell us who prescribed or gave you which controlled medications and why. This requirement is for your safety and allows us to consider possible drug interactions.

You also understand that you should use the same pharmacy every time you fill a prescription. You agree to call us if there is a reason to use a different pharmacy. This requirement is also for your safely

2._____Drug testing and medication counts: *I give my permission for urine, saliva or blood screening as requested by my treating doctor at any time. I understand that is my doctor's responsibility to make sure my treatment plan is safe, effective and that I am following the treatment plan. I understand that a drug screen is a laboratory test of samples of my urine, saliva or blood that I provide to check the drugs that I have been taking. I understand that my drug screening test results will be a part of my medical record. I understand that I may be asked to bring in all of my medications at any time to be counted. This is on measure of how well I am able to follow my treatment plan.*

We use drug testing and pill counts in this practice to look at risk of safety issues. We do not perform drug testing or medication counts to punish you. We do this to monitor risk and safety as required by professional medical guidelines and rules.

3._____Take medications ONLY as prescribed. *I agree to take each of my medications as the prescribed dose and frequency. This means I will not run out early. If I think my medication is not working, or that I am having a medication problem, I will call this office and ask to speak with my doctor for guidance.*

Controlled medications are powerful and can cause harm if not taken according to the doctors instructions. Using controlled medication in a way other than as directed by your doctor may cause you to have more health problems and could kill you. Follow the written directions on your prescription bottle and call your pharmacist and this office if you have questions.

4._____Medication safety: *I will safeguard my medications and prescriptions. I understand that lost, stolen or damaged medication will not be replaced. I will store my medications in a safe, secure, locked place to prevent theft, loss or use by others. I will keep all medications away from children of any age.*

Allowing someone else to take your medication can make another person sick or cause them to die. These medications are prescribed for you and only you. We emphasize the safe use, storage, and disposal of all medications. Use mediation ONLY as directed.

5._____Is this the right medication for me*: I understand that my physician may stop, taper, or change my prescribed medication:*

-IF my activity and function level have not improved

-IF I do not show improvement of pain

-IF I develop significant side-effects from the medication

-IF I give, sell or misuse any of my medications

-IF I demonstrate that I am unable to follow this agreement and my physician feels she/he can no longer prescribe my pain medication safely and effectively.

This will be documented in my medical record.

6._____Agreement NOT to use illegal drugs or other pain medications: I agree not to use illegal or street drugs. I agree not to abuse alcohol. I agree not to take any medications prescribed for someone else. I agree not to use over the counter medications or any other medically active substance without the agreement of my treating physician. I may be prescribed medication by another licensed provider and I will notify EVERY treating physician of all medication I am taking. If I am prescribed other or additional pain medications due to surgery or to injury I will notify the health care provider caring for me that I have a pain medication agreement. I will promptly let my pain medicine prescriber know that I have received additional medication.

Using illegal or street drugs is a bad idea. Using other medication not prescribed by your pain medicine prescriber to treat your pain or pain-related medical problems is a bad idea. If you use illegal drugs or other controlled medications, your doctor may decide to stop prescribing controlled medications for you.

7._____Consent to share this agreement with other health care professionals and the hospital for coordination of my medical care: *I give my permission for my treating physician to share the contents of this agreement and to discuss all my medical conditions and treatment detail with pharmacists, (including Emergency Departments and Urgent Care Centers), or other healthcare professionals for the purpose of coordinating my care. I give permission for all the above to report violations of this agreement to my physician. I understand that this agreement may be added to my medical record at the hospital so that if I do have an emergency visit or surgery, my treatment plan will be considered. I understand this is to help keep me safe.*

I understand that my permission is not required for my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of my pain medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

By signing this document, you agree that we can share this agreement with any health care professional in the coordination of your medical care. In this case, coordination of care means the evaluation of your health, medical treatment and safely issues associated with the use of controlled medication.

Patient signature:_____Date:_____

Patient name PRINTED:_____

Prescribing Physician signature:_____

Copy of this signed Agreement to be given to: the patient and the patients chart.