Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OPIOID TREATMENT AGREEMENT

Patient Name: _____ **Claim No.** _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.
I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. **I understand that I have the following responsibilities:**
   a. I will take medications only at the dose and frequency prescribed.
   b. I will not increase or change medications without the approval of this provider.
   c. I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
   d. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood altering drugs.
   e. I will inform this provider of all other medications that I am taking.
   f. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.
   g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
   h. I agree to participate in psychiatric or psychological assessments, if necessary.
   i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
      - 12-step program and securing a sponsor
      - Individual counseling
      - Inpatient or outpatient treatment
      - Other: _____

2. **I understand that in the event of an emergency,** this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other provider without this provider's approval.

3. **I understand that I will consent to random drug screening.** A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. **I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.**

5. **I understand that this provider may stop prescribing opioids or change the treatment plan if:**
   a. I do not show any improvement in pain from opioids or my physical activity has not improved.
   b. My behavior is inconsistent with the responsibilities outlined in #1 above.
   c. I give, sell or misuse the opioid medications.
   d. I develop rapid tolerance or loss of improvement from the treatment.
   e. I obtain opioids from other than this provider.
   f. I refuse to cooperate when asked to get a drug screen.
   g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   h. If I am unable to keep follow-up appointments.

Patient Signature	Date	Provider Signature	Date

PLEASE READ AND SIGN REVERSE SIDE

Provider:
Keep signed copy in file, give a copy to patient and send a copy to L&I.
Must renew Agreement every 6 months.

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Patient Name: _____ **Claim No.** _____

Your safety risks while working under the influence of opioids

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

Side effects of opioids

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Vomiting
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Dry mouth

These side effects may be made worse if you mix opioids with other drugs, including alcohol.

Risks

Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

- Runny nose
- Abdominal cramping
- Rapid heart rate
- Diarrhea
- Sweating
- Nervousness
- Difficulty sleeping for several days
- Goose bumps

Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
Tolerance. This means you may need more and more drug to get the same effect.
Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your provider.

Payment of medications

State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your provider should discuss other sources of payment for opioids when L&I can no longer pay.

Recommendations to manage your medications

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature	Date	Provider Signature	Date

PLEASE READ AND SIGN REVERSE SIDE

Provider:
Keep signed copy in file, give a copy to patient and send a copy to L&I.
Must renew Agreement every 6 months.

Model Pain Management Agreement

I, _____(*patient receiving chronic **pain** medications),*agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____(name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

_____I will only take medications at the amount and frequency prescribed.

_____I will not increase or change how I take my medications without the approval of my pain management provider.

_____I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.

_____I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy:_____Phone Number:_____

_____I will allow my pain management provider to provide a copy of this agreement to my pharmacy.

_____I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.

_____I understand that other physicians should not change doses of my pain medications made by another provider.

_____I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.

_____I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.

_____In event of an emergency, I will give this same information to emergency department providers.

_____I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.

_____I will inform my pain management provider of any new medications or medical conditions.

_____I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

_____I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

_____In addition, I will do the following (initial each box):

- _____I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan. Contact number is 1-800-562-1240)
- _____I must take a drug test this often: _____
- _____I agree to pill counts to prove I am using my medications correctly
- _____If I fail a drug test, I will take the drug test more often at (frequency of) _____
- _____If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (**http://maa.dshs.wa.gov/PRR**)
- _____If I sell my narcotics, my name will be referred to the DSHS fraud unit.
- _____If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

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:_____
Provider: _____Clinic:_____Phone:_____

Patient Signature: _____

Provider Signature: _____