MANGO Medical Clinic
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Patient Agreement for Opioid Therapy

Patient name: _____

DOB: _____

PHN: _____

One source for prescriptions

1. I agree that Dr. _____ will be the **only one physician** prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at **only one pharmacy**. The exception would be when my doctor is unavailable, at which time I will see one of his or her colleagues in the same clinic if possible. I understand that in an unlikely event of a pain crisis, I may have to attend the emergency room but I will update my doctor as soon as possible.

Adherence to prescription

2. I will take the medication at the dose and frequency prescribed by my physician. I agree **not to increase the dose** of opioid without first discussing it with my physician. I will **not request earlier prescription refills**.
3. I will attend all reasonable appointments, treatments and consultations as requested by my physician. I agree to other **pain consultations/management strategies** as necessary.

Side effects

4. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to **refrain from driving a motor vehicle or operating dangerous machinery** until such drowsiness disappears.
5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.

Drug screening

6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician will require that I have **random blood,**

urine or hair testing and/or see a specialist in addiction medicine. I will comply with these testing and treatment as recommended by my doctor.

7. If I get a phone call to give an urine sample for a random drug screen, I will have 24 hours to comply.
8. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances. I understand that as I cannot safely continue opioid treatment **if I take these mood-modifying substances, my opioid treatment will be tapered and terminated**.

Maximum amount

9. I understand that the College of Physicians and Surgeons of BC (CPSBC) has mandated a **maximum amount of opioids** that can be legally prescribed. I will not receive a prescription that exceeds this amount.
10. I understand that the CPSBC had mandated that **no more than 1 month supply** of opioids can be given; and a shorter supply may be deemed medically necessary by my doctor.

Use with benzodiazepines and other drugs

11. I understand that the CPSBC has forbidden the long term use of **opioids** and **sedatives** (such as ativan, clonazepam, zopiclone, diazepam, etc) and I will be given at most **3 months to taper** off one of these medications.
12. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.

Safe storage

13. I agree to be responsible for the secure, locked storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Lost medication **will not be replaced** until the next regular renewal date.

Consent to PharmaNet

14. I **consent to open communication** between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
15. **I formally consent to my doctor checking my PharmaNet records on a regular basis.**

16. I understand that if I break this agreement, or if there is any other reason for my doctor to be concerned about my safety, my doctor is **legally obligated to stop prescribing opioid medications.**

Patient signature: _____ Dated: _____