Place Patient Form Label Here

BCC PATIENT AGREEMENT FOR OPIOID THERAPY

* 7 5 7 3 *

Consent Other

Please read and fill out the agreement below.

1. I, _____ agree that the Doctors at the BC Cancer's Pain and Symptom Management clinics will be the only physicians prescribing OPIOID (also known as NARCOTIC) pain medication for me.

2. I will obtain all of my prescriptions for opioids at one pharmacy. The exception would be an emergency situation. Should such an occasion occur, I will inform my health care providers at the next clinic visit.

3. 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 early prescription refills.

4. I will attend all reasonable appointments, treatments and consultations as requested by my health care providers.

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.

6. I understand that urine drug testing is a routine component of long term opioid treatments and I may be asked to provide urine for drug testing on request.

7. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illegal drugs (such as cannabis (marijuana), cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree not to use these substances without prior agreement from my physician.

8. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. I know that lost medication will not be replaced until the next regular renewal date.

9. If I am unable to comply with this agreement, I understand that my physician may not be able to continue prescribing opioids for me and may need to make other arrangements for my care.

Date: _____

_____
Patient signature

_____
Physician signature