KANIKSU COMMUNITY HEALTH

WHOLE HEALTH FOR YOUR WHOLE LIFE

www.kchnorthidaho.org

Pain Management Agreement (Form: PCMH CG 07-a)

Patient: _____ Provider: _____

Patient's DOB: _____ Designated Pharmacy: _____

Diagnosis: _____

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

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

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

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, locked place to prevent theft, loss or use by others. I will keep all medications away from children of any age.

5. _____ **Is this the right medication for me?** I understand that my physician may stop, taper, or change my prescribed medication:
   a. If my activity and function level have not improved.
   b. If I do not show improvement of pain.
   c. If I develop significant side-effects from the medications.
   d. If I give, sell, or misuse any of my medications.
   e. If I demonstrate that I am unable to follow this agreement and my provider 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 medication 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 provider. I may be prescribed by another licensed provider and I will notify EVERY treating provider of all medication I am taking. If I am prescribed other or additional pain medications due to surgery

or 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.

7. _____ **Pain Medicine refill request**. I agree to only request a refill request for my pain medicine during an office visit or during regular office hours (Monday- Friday). I acknowledge that I have been informed that pain medications will not be refilled during the evening hours or on the weekend.

8. _____ **Release of information**. I agree that my provider can contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain and provide information about my care or actions if the provider feels it is necessary.

9. _____ **Acknowledgement of the side effects of opioid therapy**. I am aware that the side effects of opioid therapy may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and or motor ability (problems with coordination or balance than may make it unsafe to operate dangerous equipment or motor vehicles . Overuse of opioids can cause decreased respiration (breathing), and may actually increase pain sensitivity.

10. _____ **Referrals**. Patient with a history of addiction, alcohol use or mental health diagnosis will agree to see Behavioral Health. All patients will agree to a Behavioral Health or Physical Therapy evaluation or participation in self-management classes when recommended by the provider.

11. _____ **Acknowledgement of physical dependence and/or tolerance of opioid medication**. I understand the following:
    a. Physical Dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but is not limited to, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one 's mood.
    b. Tolerance means the state of adaptation in which exposure to the drug causes changes that result in decrease of one or more of the drug's effects over time. The dose of the opioid may have to be changed up or down to a dose that produces maximum function and a realistic decrease of the patient 's pain.

12. _____ **Termination**. I agree that if I do the any following, I will not receive any controlled medication from any provider at Kaniksu Community Health.
    a. If I am found in possession of illicit drugs or substance
    b. If I am trafficking in controlled or illegal substances
    c. If I am intoxicated or arrested for a DUI
    d. If I alter my prescription in any way
    e. If I sell or share my medications.

The above agreement has been explained to me by (provider name) _____

I agree to its terms so that (provider name) _____ can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Revisit agreement: Annually _____

Bi-annually _____

Patient's Signature: _____ Date: _____