Vitruvian Health

Opioid Treatment Agreement

The purpose of this agreement is to prevent confusion about medicines you will be taking for pain management. This is to help both you and your clinical team to comply with the laws regarding controlled medications. **Please initial where indicated next to each line item.**

_______ I understand this agreement is essential to the trust and confidence necessary to establish a strong doctor/patient relationship. I will inform my clinical provider of all medicines which I am prescribed.

________ I understand mixing medications that have not been prescribed to me by my provider can result in bodily harm and possibly death.

________ I understand that if I break this agreement, my clinician may stop prescribing controlled pain medicines to me. In this case, my clinician may taper me off the medicine over a period that is appropriate to avoid withdrawal symptoms. I also realize a drug-dependence treatment program may be recommended in conjunction with an opioid taper.

________ I will communicate fully with my clinician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to improve my overall functionality and ability to complete activities of daily living.

________ I will not use illegal substances, including but not limited to: Cocaine, heroin, mushrooms, LSD, etc.

________ I will not share, trade, or sell my medications with anyone.

________ I understand my opioid medications will be prescribed by only one clinician and I agree to fill my prescriptions at only one pharmacy.

________ I agree not to take any pain or mind-altering medications prescribed by any other clinician without first discussing it with my Vitruvian Health provider.

________ I give Vitruvian Health permission to verify I am not seeing any other physicians for opioid medications or going to other pharmacies to fill my controlled medicines.

________ I agree to store my controlled medications safely and understand that lost, stolen or misplaced medications may not be replaced without a valid police report.

________ I agree to take these controlled medicines as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing clinician.

________ Running out early, needing early refills, or escalating doses without permission are signs of misuse and may be a reason for my provider to terminate this agreement.

________ I agree that refills of my controlled medications will be made only at my scheduled office visits. I also agree to make a return office visit prior to my prescriptions running out, typically every 28 days.

________ I will bring all unused medications with me to each appointment and realize failure in doing so is a violation of this opioid agreement.

________ No refills will be provided without a scheduled appointment.

________ I will go to all appointments, treatments, and meetings my provider refers me to, such as Behavioral Health.

________ I understand I will be subject to regular and random urine drug tests to ensure I am taking my prescribed medications and avoiding non-prescribed controlled medications and illicit drugs. Failure to comply with urine drug testing protocols will result in termination of this agreement and no further controlled medications will be prescribed to me.

________ I agree that disruptive behavior in the clinic, by telephone, or other electronic media will not be tolerated and will result in immediate termination of this agreement and dismissal from Vitruvian Health.

________ I understand that controlled medicines have side effects that can affect thinking ability, decreased reaction time, confusion, constipation, dry mouth, vomiting, agitation, depression, sleepiness, drowsiness, problems with coordination or balance that may make it unsafe to operate equipment or motor vehicles, hormone imbalance, decreased respiratory rate, addiction, and death. These side effects can be made worse if opioids are taken with other drugs, including alcohol.

________ I understand there is a risk of opioid addiction when taking opioid medications. People with a history of alcohol or drug abuse are more susceptible to addiction. Should I exhibit signs of addiction, the medications I am being prescribed will be discontinued and I will be referred to a drug treatment program.

_________________________	____________________________	___________________
Patient Name	Patient Signature	Date
_________________________	____________________________	___________________
Provider Name	Provider Signature	Date