**Patient Agreement for Opioid Therapy**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree that Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (or their locum) will be the only doctor prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy, namely \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. I understand that initiating or continuing this medication is a trial, and that if there is no improvement in function after \_\_\_\_\_\_ months (such as being able to go back to work, not simply improvement in pain) then the opioid will be stopped.
3. I will take the medication at the dose and frequency prescribed by my doctor. I agree not to increase the dose of opioid without first getting approval from my doctor.
4. I will not request earlier prescription refills, and I accept that as per the law, one month maximum is given for any script, and no future dated scripts will be given.
5. I will attend all reasonable appointments, treatments and consultations as requested by my doctor. I agree to other pain consultations/management strategies as necessary.
6. I understand that the common side effects of opioid therapy include nausea, constipation, sweating, itchiness of the skin, reduced sex hormones (e.g. lower testosterone), low bone density, and weakened immune system. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving any motor vehicles or operate dangerous machinery until such drowsiness disappears.
7. I understand that using opioids to treat chronic pain may result in the development of dependence (addiction) to the medication. If this occurs (as diagnosed by my doctor) I understand that New Zealand law is very clear in that my doctor can no longer legally prescribe the opioid for me. If the opioid needs to be weaned off, then I agree to see an addiction specialist who can legally prescribe it in this situation.
8. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as marijuana/cannabis, cocaine, heroin or hallucinogens) can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all these substances without prior agreement from my doctor.
9. I understand that I may be required to undergo random drug testing to document that I am not taking any other substance that my doctor doesn’t know about.
10. 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. Scripts claiming to be lost, or medication stolen or donated will not be replaced.
11. 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.
12. I understand that if I break this agreement, my doctor reserves the right to stop prescribing opioid medications for me.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Signature - Patient) (Signature - Doctor)