

TOOLBOX 4. EXAMPLE OF A TREATMENT CONTRACT FOR THE USE OF OPIOIDS FOR THE MANAGEMENT OF CHRONIC PAIN*

Patient name: _____

Address: _____

Date of birth: _____

I, [Add name here], understand that opioid painkillers are being prescribed to me in an attempt to improve my level of functioning and reduce my pain intensity. My medical practitioner and I agree to the following conditions regarding my treatment and the prescribing of opioid medications for my pain. We have discussed that strong opioid (morphine-like) painkillers may be only partially helpful in achieving this goal and on occasion will not help at all. I understand that painkillers are only one part of the management of my chronic pain.

1. My medical practitioner is responsible for prescribing a safe and effective dose of opioids. I will not use opioids other than at the dose prescribed and I will discuss any changes in my dose with my medical practitioner.
2. I am responsible for the security of my opioid medicine. Lost, misplaced or stolen prescriptions or medicine will not be replaced.
3. I will only obtain opioid medications from the medical practitioner who signs this contract, or other doctors in the same practice authorised to prescribe to me. I understand that no early prescriptions will be provided.
4. Whilst most people do not have any serious problems with this type of medicine when used as directed, there can be side effects. My medical practitioner will let me know what these are and I will tell him or her if I experience them.
5. I am aware that my medical practitioner is required to gain authorisation from the Department of Health for continued prescription of these medications.
6. I agree to tell my medical practitioner if I have ever been dependant on alcohol or drugs, or if I have ever been involved in illegal activity related to any drugs including prescription medicines. I am aware that providing my medicine to other people is illegal and could be dangerous to them.
7. My medical practitioner respects my right to participate in decisions about my pain management and will explain the risks, benefits and side effects of any treatment.
8. My medical practitioner and I will work together to improve my level of functioning and reduce my pain.
9. I understand that my medical practitioner may stop prescribing opioids or change the treatment plan if my level of activity has not improved or I do not show a significant reduction in pain intensity, or if I fail to comply with any of the conditions listed above.

Patient signature: _____

Name: _____

Date: _____

Medical practitioner: _____

Provider number: _____

Date: _____