

## Pain Management Patient Care Agreement

Effective pain management requires that the patient and clinician work together. This agreement is designed to make sure that you understand your obligations and the conditions of your care.

If you do not understand any part of this agreement, please talk with your clinician. If you do not fulfill your obligations in your care, we will be less effective in helping you. We might even have to stop treating you.

1. I will take my pain medications as prescribed. I will not increase or decrease the dose on my own. I will not take more than is prescribed, so I will not run out early.
2. The \_\_\_\_\_ clinic provider will prescribe enough medication to last until my next visit or next scheduled medication refill date.
3. I will not request, and will not be provided with early refills. I understand that it is my responsibility to keep track of my pain medications. I must allow at least \_\_\_ **business days** for them to be refilled. I understand that if I allow less time than this, I may have to go without.
4. Refills will not be provided on an emergency basis, after hours, on weekends, or on holidays. On-call providers will not provide refills of my pain medication.
5. Prescriptions are like money. If I lose my medication or the written prescription slip, neither will be replaced. I will have to wait until my next visit or scheduled refill date.
6. I agree to take only my own medications. I will not take someone else's medication, even if I think it is the same medicine. I will not share my medications with anyone else.
7. My \_\_\_\_\_ clinic providers will be the only clinicians prescribing my long-term pain medications and other controlled substances (opioids, tranquilizers, muscles relaxants, and/or sedatives).
8. If I require more pain medications from another provider for an acute injury or procedure, I will not use my long-term medication for this problem. I will disclose my full medication list and the existence of this Pain Management Patient Care Agreement to this other provider, and arrange to have him/her provide refills of the new medication. **I must let my \_\_\_\_\_ clinic providers know about any medicines prescribed for me by other doctors or any other health care providers within 48 hours or 2 business days of the change.**
9. I understand that I may fill my first prescription at the pharmacy of my choice. After that, all refills must be made with the same pharmacy. My \_\_\_\_\_ clinic provider must agree to any change of pharmacy.
10. I agree not to take or use any street or recreational drugs, other controlled substances, or unauthorized substances during the course of my treatment.
11. I agree to advise my prescribing provider of any over-the-counter drugs, vitamin supplements, and/or herbal remedies I am taking. I agree to disclose my full medication list.
12. I understand that my provider may request blood or urine drug tests to help guide my treatment.
13. I will keep all of my follow-up appointments.

PT.NO

NAME

DOB

### UW Medicine

Harborview Medical Center – UW Medical Center  
University of Washington Physicians  
Seattle, Washington

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**\*U0000\* Draft**

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14. Lowering my dose over time will help me know if I still need pain medicines. Once the right dose for me is determined, the medication management *may* be transferred to a primary care provider.
15. If other treatments are needed, such as physical therapy or counseling, I agree to follow through with the entire program. I understand that I will not continue to receive pain medications unless other therapy appointments are kept.
16. If I do not comply with the above, then I understand that my pain medications will be stopped after tapering the dose.

By signing below, I am saying that I:

- Agree to these obligations and conditions.
- Have read them and understand them.
- Have received and reviewed the handout "About Your Pain Management."
- Have had my questions answered to my satisfaction.
- Will notify my prescribing providers if I feel I will not be able to honor the commitments made in this agreement.

My Primary Care Provider: \_\_\_\_\_

My Pharmacy Name, Phone Number and Location: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Signatures:

Patient: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Provider: \_\_\_\_\_

Witness: \_\_\_\_\_

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