Pain Management Agreement

The State of Florida requires that patients who receive prescriptions for **chronic non-malignant pain** enter into a written controlled substance agreement outlining a patient’s responsibilities.

The State of Florida defines chronic non-malignant pain as pain not caused by cancer or rheumatoid arthritis. It is also pain that lasts longer than usual for the condition or injury that causes the pain. Pain that lasts longer than 90 days after surgery is also considered chronic non-malignant pain.

The State of Florida also requires pharmacies and those physicians that provide controlled substances at their offices to enter into a state database the fact that you have filled a prescription for a controlled substance. The State also monitors physicians that treat patients for this type of pain.

More importantly, this agreement shows that you have been given important information about controlled substances and what is expected of you during your treatment.

I acknowledge the following:

I have been informed of the following risks and benefits of taking controlled substances:

1. **Benefits:** temporary pain relief, allowing me to perform activities of daily living.
2. **Risks:** dizziness, injury, drug dependence, overdose, constipation, potential for abuse or addiction

I will receive prescriptions for enough medications for 3 months. If I need a refill prior to my scheduled visit, I will be given a prescription for no more than a 2 week supply.

I will request treatment for chronic pain from only one physician, unless otherwise authorized by my physician, which shall be documented in my medical record.

I agree to tell any of my other physicians what medications I am taking. I agree not to seek pain medications from other physicians, unless I am in the Emergency Room or having a surgical procedure and I have informed the Emergency Room or the physician of the medications I take for pain.

I agree I will not abuse alcohol. If my provider advises, I will not have any alcohol.

I understand that if I do not follow this agreement, I will no longer receive drug therapy treatment and my physician shall discharge me from the practice immediately, without advance notice and the physician will stop prescribing pain medications. If needed, I will be given instructions on reducing my medications gradually, as stopping some pain medications
suddenly can cause withdrawal symptoms, stroke, heart attack, seizures, permanent damage, and possibly death.

I will communicate with the physician and staff about the nature, duration, intensity of my pain and what works to relieve it.

If it appears to my physician that there is no improvement to my daily function or quality of life by taking the medications, I agree to work with my physician to gradually decrease the dosage, or seek a different treatment approach.

I agree to take my medications no more frequently than ordered and agree not to take any family or friend’s pain medications

I will not share my medications with anyone and will not sell them to anyone.

I will not use illegal substances, such as marijuana or cocaine.

I agree to submit to a blood or urine test at any time, ordered by physician, so my physician can check my compliance with my pain control program.

I agree to keep my medications in a safe and secure place.

I acknowledge that there is a risk that I may become dependent or addicted to these medications. People that have a history of addiction have a greater risk of addiction. If I do have a history of addiction, psychiatric disorders, or become addicted, I agree to inform my physician, who may consult with or refer me to a specialist that deals with addiction.

I authorize my physician to cooperate with law enforcement agencies and the Board of Pharmacy regarding any regulatory matter, including possible diversion or misuse of my medications. I also authorize my physician to give a copy of this agreement to the pharmacy.

I have read this agreement and agree to follow it. I am aware that if I violate this agreement, my physician will discontinue this treatment and my physician will discharge me from his practice, which means he is not my physician.

___________________________________   _____________________________
Patient Signature                      Date

___________________________________   _____________________________
Physician Signature                   Date