



PAIN MANAGEMENT GUIDELINES AND CONTRACT

Name _____

DOB _____

Goals for Taking Opioid Medications: _____

I, _____, understand that compliance with the following guidelines is important to the continuation of pain treatment by _____

1. I will take medications at the dose and frequency prescribed. No other pain medications are to be taken unless discussed first with _____
2. I will comply with my scheduled appointments.
Next appointment: _____
3. No pain medication will be refilled by phone. I understand that pain medication prescriptions will only be refilled at the scheduled clinic appointments.
4. I will not request controlled-substances or any other pain medicine from prescribers other than _____
5. I will consent to random drug testing.
6. I will protect my prescribed medications. No lost or stolen medications will be replaced.
7. I will tell all my physicians that I am receiving pain treatments through and/or from _____
8. I agree to participate in psychiatric, neuropsychology and substance abuse assessments.
9. This agreement will be placed in my medical record.
10. I understand that if I have any questions or concerns regarding my pain treatment that I will call my primary care provider at _____

I have read and understand the above guidelines.

Patient

Date

Physician

Date