360 SPINE CARE
a Division of Vascular and Interventional Radiology of Community Care Physicians

Leading the way to better spine health.

Prescription Pain Medication Agreement

This is an agreement between _____ (patient) and Dr. _____
I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will hopefully decrease it enough that I can be more active.
I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge that my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and how often I take my medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Patient Initials	**Please read the statements below and initial in the box on the left.**
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my doctor of all side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking the medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Dr. _____
	I will fill this prescription at only one Pharmacy (Pharmacy information given below).
	I will keep my medication in a safe place. I understand that is my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescription refill if I miss my appointment.

Medication name, dose and frequency: _____
_____
_____
_____
_____
_____

Pharmacy name: _____

Pharmacy phone number: _____

_____ Date: _____

Patient signature

DOB: _____

_____ Date: _____

Physician signature