Appendix 11 - Opioid Management Plan: Treatment Agreement (17)

Patient Name: …….…… NHS number: ……..

Condition(s) being managed with opioids:

New opioids being commenced as this agreement is being implemented:
(This is for a trial period during which the prescriber will need good evidence of improvement in function to embark on long term treatment)

Period before next mandatory review:
(For new trials 2-4 weeks, for long-term prescription 6–12 months)

Patient Declaration

In signing this agreement, the patient agrees to the following conditions regarding his/her treatment and the prescribing of an opioid medication:

1. I have read the Thinking About Opioid Treatment for Pain and Taking Opioids for Pain information leaflets and I will tell my GP if I experience on-going/intolerable side effects.
2. My GP is responsible for prescribing a safe and effective dose of the opioid medication. My GP will control my dose, perhaps with advice from one or more hospital specialist in a condition relevant to my pain.
3. I will follow the directions given to me by my GP; I will not increase my dose and will discuss any changes in my dose with my GP.
4. I will not use any other opioids in addition to those prescribed by my GP.
5. I will only obtain my opioid medication from my GP.
6. I understand that no early prescriptions will be provided.
7. Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources, uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.
8. I am responsible for the security of my opioid medication at home. Lost, misplaced or stolen medication or prescriptions for opioid medicines may not be replaced. In the event that opioid medication is stolen, I will report this to the police.
9. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.
10. I understand that if my level of activity has not improved, I do not show a significant reduction in my pain, or if I fail to comply with any of the conditions listed above my opioid prescription may be changed or stopped.

Patient's Signature: …….. ……. Date: …….

Medical Practitioner's Signature: …… Date: …….