-Sample Pain Management Contract-

The following Pain Management Contract is only a sample. Practitioners are not required to use this particular contract to meet the requirements of OAR 851-050-0170. By providing this sample, the Oregon State Board of Nursing disclaims any and all liability that may result from its use. Practitioners should consult with their own legal counsel to determine appropriate documentation with their patients.

Informed Consent Agreement for Treatment of Intractable Pain with Narcotics

I have been diagnosed with _____ which is the cause of my intractable pain. This diagnosis has been confirmed in consultation with _____MD/NP.

The medication that I have been prescribed for treatment of my condition is_____

_____

I understand that there are alternative treatments which include _____

_____

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my day to day functioning.

I understand that daily use of a narcotic increases certain risks, which include but are not limited to:

- Addiction
- Nausea, vomiting and constipation.
- Impaired judgement, sleepiness, and confusion.
- Allergic reactions, overdose and fatal complications
- Breathing problems
- Dizziness
- Impaired ability to operate machines or drive motor vehicles
- Development of tolerance

I agree to the following guidelines:

1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider.

2. I will submit to random urine or blood tests if requested by my nurse practitioner to assess my compliance.

3. I will obtain all my prescriptions through ___(nurse practitioner)_____ and will fill all prescriptions at _____(pharmacy)_____. In an acute emergency another provider may prescribe medications for me. If this occurs I will notify my primary care nurse practitioner as soon as possible.

4. Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication. Refills will only be made during regular office hours.

5. I agree to see ____(nurse practitioner)_____ for on-going case management and will schedule regular appointments as long as I am taking this narcotic medication.

6. If I do not follow these guidelines I understand that my treatment may be terminated.

I have discussed the risks, benefits and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

_____ _____

Patient Signature Date Provider signature Date