Opioid Management Plan: Treatment Agreement

Patient Name: ……………………………………………………………….
NHS number: ……………………………………………………………….

Condition(s) being managed with opioids:

New opioids being prescribed when this agreement starts:

(This is for a trial period during which the prescriber will need good evidence of improvement in function before embarking 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 their treatment and the prescribing of an opioid medication **[Delete points as necessary]**:

1. I have read the 'Thinking About Opioid Treatment For Pain', Driving-and-Pain-patient-information and 'Taking Opioids For Pain' information leaflets and I will tell my GP practice team if I experience any on-going/intolerable side effects.
2. I agree to follow a medicine free alternative pain management pathway as signposted by my GP practice team, if I am asked to do so.
3. I agree that my GP practice team is responsible for prescribing a safe and effective dose of the opioid medication. They will control my dose, with advice from one or more hospital specialists in a condition relevant to my pain if necessary.
4. I will follow the directions given to me by my GP practice team; I will not increase my dose and will discuss any changes in my dose with them.
5. I will only use opioids prescribed by my GP practice team.
6. I will only obtain my opioid medication with prescriptions from my GP practice team.
7. I understand that prescriptions will not be provided before they are due according to your agreed treatment schedule.
8. I will report any side effects/withdrawal symptoms to my GP practice team.
9. I understand that any evidence of unsafe use may result in closer monitoring and increased frequency of prescription collection with reduced amounts of opioids.

   Examples of this are:

   - drug hoarding;
   - acquisition of any opioid medication or other pain medication from other sources;
   - uncontrolled dose escalation;
   - continual loss of prescriptions;
   - failure to follow the agreement
10. I am responsible for the security of my opioid medication at home. I understand that 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.

11. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.

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

Clinician's Signature:……………………………………………………………………………………… Date: ……………………………….