Pain Management Agreement

Per ESHB 2876 WAC 246-919-856

A copy of this signed Agreement will be given to the patient and a copy attached in their chart / EHR

The management of chronic pain is a complex problem and pain medications may be part of the treatment plan. The purpose of this agreement is to protect the safety of the patient and the community and to clearly establish expectations of how these medications are to be safely managed. These are potentially dangerous medications that are highly regulated and can cause serious injury or death if misused. When you sign this agreement with Northwest Neurological (NWN), it means that you understand that taking your medications, even as prescribed, may trigger other issues. For example, when taking opiate medication you may have cravings for more opiates. Habituation to opioids could put you at risk of developing an addictive disorder. To acknowledge your consent of the following rules of this agreement please initial next to each item as it is read and understood.

1. _____ **Only ONE (1) prescriber and ONE (1) pharmacy:**

I agree to receive pain medications only from NWN (or from someone designated by NWN). I agree to receive my pain medications only from my designated pharmacy noted below.

If you receive pain medications from another health care professional because of a true emergency, injury or accident requiring urgent care, you agree to tell that practitioner about your agreement with NWN and you agree to call NWN within one business day to inform NWN and plan further action if necessary. You also understand that you should use the same pharmacy every time you fill a prescription. You agree to call NWN if there is a reason to use a different pharmacy.

2. _____ **Drug testing and medication counts:** *I give my permission for urine, saliva or blood screening as requested by NWN at any time. I understand that my drug screening test results will be part of my medical record. I understand that I may be asked to bring in all of my medications at any time to be counted.*

3. _____ **Take medications ONLY as prescribed.** *I agree to take each of my medications at the prescribed dose and frequency. If I think my medication is not working, I may run out, or that I am having a medication problem, I will call NWN during normal business hours as soon as possible.*

Many medications are powerful and can cause harm if not taken according to the provider's instructions. Using medications in any way other than as directed by NWN may cause you to have more health problems and could kill you. Follow the written directions on your prescription bottles and call your pharmacist and NWN if you have questions.

4. _____ **Medication safety:** *I will store my medications in a safe place because lost or stolen medication will not be replaced. I also need to keep all medications away from children or others who might be at risk of taking the medications without authority.*

Allowing someone else to take your medication can make another person sick or cause them to die. These medications are prescribed for you and only you. We emphasize the safe use, storage, and disposal of all medication. Use medication ONLY as directed.

5. _____ **Is this the right medication for me:** *I understand that NWN may stop, taper, or change my prescribed medication at any time, but also specifically:*

-IF my activity and functional level have not improved or IF *I do not show improvement of pain -IF I develop significant side-effects* or *IF I give, sell or misuse any of my medications*

-IF I demonstrate that I am unable to follow this agreement and NWN feels she/he can no longer prescribe my pain medications safely and effectively.

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6. _____ **Agreement NOT to use illegal drugs or other pain medications:** *I agree not to use illegal drugs or street drugs. I agree not to abuse alcohol. I agree not to take any medications prescribed for someone else. I may be prescribed medication by another licensed provider and I will notify EVERY treating physician of all medications I am taking within one business day. If I am prescribed other or additional pain medications due to surgery or to injury I will notify the health care provider caring for me that I have a pain medication agreement. I will promptly let my pain medicine prescriber know that I have received additional medication(s).*

7. _____ **Consent to share this agreement with other health care professionals and the hospital for coordination of my medical care:** *I give my permission for NWN to share the contents of this agreement and to discuss all my medical conditions and treatment details with pharmacists, physicians or other healthcare professionals for the purpose of coordinating my care. I give permission for all the above to report violations of this agreement to my physician. I understand that this agreement may be added to my medical record at the hospital so that if I do have an emergency visit, or surgery, my treatment plan will be considered. I understand this is to help keep me safe.*

By signing this document, you agree that we can share this agreement with any health care professional in the coordination of your medical care. In this case, coordination of care means the evaluation of your health, medical treatment and safety issues associated with the use of controlled medication.

_____ _____ _____

Printed Name of Patient **Signature of Patient** **Date**

Designated Pharmacy:_____

Name **Location** **Phone**

Medication(s) and Regimen	Quantity per 30 days	Date of Initial Rx (at NWN)	NWN Provider Initials

_____ _____

Signature of NWN employee **Date**

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