*Drugs of dependence therapy agreement template*

Purpose:

To inform patients about their responsibilities and expected behaviours regarding drugs of dependence.

For more information, please refer to the RACGPs [Prescribing drugs of dependence in general practice – Part A – Clinical Governance Framework](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-a).

[Insert practice name] drugs of dependence therapy agreement.

*Current as of: [insert date of last revision]*

*Version no: [insert version number]*

*Review date: [insert date]*

***Based on the Blaustein Pain Treatment Center/Johns Hopkins Medicine therapy agreement and to be modified by the practice to suit local circumstances.***

**PATIENT AGREEMENT FOR DRUGS OF DEPENDENCE THERAPY**

The purpose of this agreement is to give you information about the medications you will be taking for pain and/or mental health management at this practice, and to ensure that you and your doctor comply with all state, territory and Federal regulations concerning the prescribing of drugs of dependence.

The doctor’s goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the patient–doctor relationship and full agreement and understanding of the risks and benefits of using potentially addictive drugs to manage your condition.

A trial of long-term opioid therapy may be considered for moderate to severe pain with the intent of reducing pain and increasing function. A trial of long-term benzodiazepine therapy may be considered in very limited circumstances if other options have failed or are considered inappropriate.

In signing this agreement, you have agreed to a trial of long-term use of potentially addictive medications as part of your treatment. These drugs of dependence can be very useful, but have a high potential for misuse and are therefore closely controlled by state, territory and Federal governments. Because your doctor is prescribing such medication to help manage your condition, it is considered good practice to agree to the conditions outlined below.

**My responsibilities as a patient**

* I agree to see one doctor at one practice for all my health needs and prescriptions.
* I will have all my medications dispensed at one pharmacy.
* I agree that this medication is prescribed as a trial. If it appears to my doctor that there is no improvement in my daily function or quality of life from the controlled substance, my medication may be discontinued. I will gradually taper my medication as prescribed by the doctor.
* I will inform my doctor of all medications I am taking, including herbal remedies and illicit medication. Medications can interact with drugs of dependence and produce serious side effects.
* I will communicate fully with my doctor to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my doctor to adjust my treatment plan accordingly.
* I will not request or accept drugs of dependence from any other doctor or individual while I am receiving such medication from my doctor at the **[*Insert practice name*].**
* I understand the use of alcohol together with drugs of dependence is contraindicated.
* I will not use any illicit substances, such as cocaine, amphetamines or marijuana, while taking these medications. Use of these substances may result in a change to my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the patient–doctor relationship.
* If I have a history of alcohol or drug misuse/addiction, I must notify my doctor of such history since treatment with drugs of dependence may increase the possibility of relapse.
* I agree and understand that my doctor reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the patient–doctor relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the patient–doctor relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
* I agree to allow my doctor/healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions, if my doctor feels it is necessary.
* I understand my capacity to drive may be affected and I may be asked to cease driving.

**My prescriptions**

* I am responsible for my prescriptions. I understand that lost prescriptions will not be replaced.
* I understand that opioid prescriptions will not be mailed if I am unable to obtain my prescriptions monthly.
* Repeat prescriptions can be written for a maximum of 1 month supply and will be filled at the same pharmacy.
* Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* It is my responsibility to schedule appointments for the next opioid prescription before I leave the clinic or within 3 days of the last clinic visit.

**Taking my medications**

* I understand that the medication is strictly for my own use. My medication should never be given or sold to others because it may endanger that person’s health and is against the law.
* I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my doctor. If my medications are lost, misplaced or stolen my doctor may choose not to replace the medications or to taper and discontinue the medications.
* I am responsible for taking my medications as directed. I agree to take the medication only as prescribed.
* I understand that increasing my dose without the close supervision of my doctor could lead to drug overdose causing severe sedation and respiratory depression and death.
* I understand that decreasing or stopping my medication without the close supervision of my doctor can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, ‘goose flesh’, abdominal cramps and diarrhoea. These symptoms can occur 24–48 hours after the last dose and can last up to 3 weeks.
* Any evidence of drug hoarding, acquisition of any opioid medication or additional analgesia from other doctors (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the patient–doctor relationship.

**Monitoring effects of treatment**

* I accept that drug of dependence therapy is only part of my care, and that I must be fully compliant with additional care interventions deemed appropriate for my health.
* I accept that set appointments must be made to review ongoing therapy. This should be monthly and made at the last clinic appointment. No walk-in appointments for medication refills will be granted.
* If an appointment is missed, another appointment will be made as soon as possible. Immediate or emergency appointments will not be granted.
* I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. This extra medication is not to be used without the explicit permission of the prescribing doctor unless an emergency requires your appointment to be deferred one or two days.
* It is my responsibility to notify my doctor of any side effects that continue or are severe (eg sedation, confusion). I am also responsible for notifying my doctor immediately if I need to visit another healthcare provider or need to visit an emergency room or if I become pregnant.
* I understand that during the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my clinic doctor. After I have been placed on a stable dose, I may receive longer term therapy from my doctor but will return to the medical centre for a medical evaluation at least once every 3 months.
* I understand that a reduction of medication will occur if I have deterioration at home or work, or reduction of social activities because of medication, or due to medication side effects.
* I understand that while physical dependence is to be expected after long-term use of opioids, any signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.

**My behaviour**

I understand that there is a wide spectrum of drug misuse behaviours, including those documented below. I understand that cessation of the medication trial, or cessation of the patient–doctor relationship may occur if I display any of the following behaviours:

* presenting to the clinic intoxicated, as assessed by clinical staff
* making any physical threat to any member of staff or to other patients
* aggressively complaining about a need for medication
* persistently requesting to have my medication dose increased despite clinical advice
* taking a few extra, unauthorised doses on occasion
* visiting multiple doctors for controlled substances (doctor shopping)
* hoarding medication
* using a controlled substance for non-pain relief purposes (eg to enhance mood, sleep aid)
* starting frequent unscheduled clinic visits for early refills
* using consistently disruptive behaviour when arriving at the clinic
* obtaining drugs of dependence from family members (including stealing from older relatives)
* having a pattern of lost or stolen prescriptions
* displaying anger or irritability when questioned closely about pain
* being unwilling to consider other medications or non-pharmacologic treatments
* escalating my dose without authorisation
* testing positive for a non-prescribed drug(s) or illicit drug(s) in my urine
* injecting an oral formulation
* forging prescriptions
* selling medications
* refusing diagnostic workup or investigation
* obtaining controlled substance analgesics from illicit sources.

I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. It is no substitute for individual inquiry. Compliance with any recommendations does not guarantee discharge of the duty of care owed to patients. The RACGP and its employees and agents have no liability (including for negligence) to any users of the information contained in this publication.

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