Prescriber-Patient Opioid Treatment Agreement

This agreement is designed to share information about opioid medication which may help with your pain. The prescriber may also wish for you to complete the Opioid Risk Assessment Tool with you to reduce the likelihood of you becoming dependant on opioids*. *(*Opioid = a class of drug used to reduce moderate to severe pain e.g. morphine, oxycodone, fentanyl)*

New opioids being started:
We have agreed to trial the use of opioids as part of your treatment plan for pain management. **Our goal is to improve your quality of life whilst minimising the well-known risks of opioid medication.** Your medication will be prescribed for a trial period. **Success of your treatment depends on trust, honesty and understanding how opioids and opioid-like drugs are used.**

Medication name	Strength	Directions for use

Prescriber Declaration

In signing this agreement, the prescriber agrees with the following regarding your care and the prescribing of opioid medication:

1. I will thoroughly assess your pain and explain what is known/unknown about the best way to manage your pain - Ten Footsteps programme - Live Well with Pain
2. I will try to understand your experience of living with pain and accept your reports of pain and response to treatment.
3. I will give you information and advice to help you balance the benefits verses risks of opioid treatment (see **Appendix 3** NHS Greater Manchester Integrated Care - Opioid Prescribing for Chronic Pain: Resource Pack – 'What to discuss with the Person when considering Opioid Treatment')
4. At the end of the trial, I will review your opioid medication and discontinue it if there is an inadequate response (even if there are no other medicines available for your type of pain).
5. If your opioid medication is to continue beyond the trial **I will prescribe a safe and effective dose of opioid medication, and will not exceed the dose advised in the Lancashire and South Cumbria Medicines Management Group position statement** - High dose morphine prescribing for chronic non-cancer pain.
6. If your medication is to continue beyond the trial, I will review the effectiveness (benefits) and side-effects (harms) of your medication at least every 6 months.
7. I will respect your right to participate in making pain management decisions, including the right to refuse some types of treatment.

Prescriber's Signature …….

Print name ……Date……

Patient Declaration

In signing this agreement, you agree with the following regarding your treatment and the prescribing of opioid medication:

1. **Before** starting a trial of opioid medication the risks, side-effects and limits of treatment have been explained to me.
2. I understand that opioid medication is only treating pain as a symptom. It is not helping with the actual cause of the pain. Therefore, I am willing to learn new ways to self-manage my pain by attempting step-by-step behaviour, lifestyle changes and be open minded to referral to other services. I will explore other patient resources to educate me on how to manage my pain.
3. **I understand that achieving complete pain relief is not a realistic target.** My prescriber will aim to prescribe the lowest effective dose of opioid that will provide a realistic reduction in my pain levels.
4. I understand that initially I will be seen and assessed at short intervals to allow adjustment of the opioid dose and that I will be asked about my pain levels, quality of life and sleep. I understand that if there is an inadequate improvement in my quality of life and daily functioning my opioid medication will be stopped.
5. If the opioid provides initial benefit, I understand that my prescriber will review the effectiveness (benefits) and side-effects (harms) of my medication before 3 months then at least every 6 months, and that, **if after review and discussion, my prescribing health care professional believes the continued use of opioid medication is no longer in my best interests, they will not provide it,** and they will explain the reasons why. I will be honest with the prescriber when discussing my pain.
6. I shall follow the directions given to me by my prescriber and will not increase my dose or take extra doses.
7. I understand that early prescriptions of opioids will not be provided. (i.e. I will not be prescribed opioids in excess of the expected duration of need or just in case scenarios)
8. I shall only obtain my opioid medication from my prescriber and will not use any other opioids in addition to those prescribed by my prescriber.
9. I understand that evidence of unsafe use or drug seeking behaviour such as: drug hoarding, early ordering, loss of medication/prescriptions, uncontrolled dose escalation, acquisition of opioid medication or other pain medication from other sources, will result in the end of this agreement and slow withdrawal of opioids, so to minimise withdrawal.
10. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.
11. I am responsible for the security of my opioid medication at home. Lost, misplaced, or stolen medication or prescriptions may not be replaced. If opioid medication is stolen, I shall report this to the police and obtain a crime number. I shall also report the stolen medication to my prescriber.
12. **I understand that non-adherence with the agreement above will result in my opioid medication being re-evaluated and stopped.**

I *(insert name)* _____ have read (or it has been read to me) and I fully understand the information provided. All my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby agree to trial opioid medication and acknowledge that I have received this document.

Patient's Signature …… Date……..…