Opioid Prescribing Agreement

Patient name:

Date:

Reasons for opioid use:

I have read the leaflet about the potential adverse effects of opiates and understand that morphine and related drugs:

* are addictive and cause dependence
* if used in the short term, they can be incredibly difficult to stop or reduce
* have no evidence of medium to long term benefit in chronic pain
* have lots of evidence that they can cause harm, including increase in pain and death
* are likely to impair your ability to drive and it is your responsibility to decide if this is safe

2 weeks after initiation, I agree to a review of:

* any side effects
* my mood
* my pain diary which will include at a pain score at least twice daily

I understand that prescriptions will be stopped or reduced by 10% each week (and not increased), even if there is no alternative, if:

* my pain score does not drop by 30% or more as they are not effective
* I order more frequently than the prescription would suggest is required
* the prescriber deems the risks outweigh the benefits

I agree to a review upto every 3 months:

* to share a pain diary
* to document mood
* to review dosing

I understand that the maximum possible prescribed amount of morphine in 24 hours will be 120mg.

I agree to have my reviews with one doctor only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to have prescriptions sent to this pharmacy only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed (patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed (doctor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_