CAROLINA PAIN CENTER

Relieving Pain
Restoring Function

OPIOID TREATMENT AGREEMENT

I understand that **Dr. Matthew Swiber** and **Shanee Savoie, PA-**C may prescribe opioid medication to help me manage chronic pain that has not responded to other treatments. The goal of this medication is to lead to partial relief from pain so that my physical, emotional and social function will improve. If my activity level or general function gets worse, the opioid may be stopped or changed to a different prescription. The risks, side effects and benefits of opioid treatment have been explained to me, and I agree to the following instructions. Failure to follow these instructions may result in not having the medication prescribed or possible discharge from Carolina Pain Center.

1. I will participate in any **other treatment recommended** by my provider. I will be ready to decrease or stop the opioid medication when other effective treatments become available.
2. I will take my medications **exactly as prescribed** and will not change the medication schedule or dosage without advance approval from my provider.
3. I will keep regular appointments with my provider.
4. All opioid and other controlled drugs for **pain** must be prescribed by my providers at Carolina Pain Center.
5. I will inform my provider within one **business day** if I am hospitalized for any reason, or if a have had an ER visit or another condition that requires the prescription of a **controlled drug** (like narcotics, tranquilizers, barbiturates or stimulants).
6. I will choose **one pharmacy** where all of my prescriptions will be filled. **Pharmacy Name/location**:
   _____
7. I understand that lost or stolen prescriptions will **not be replaced,** so I will keep my prescription and medication in a safe place. I will not under any circumstances sell, lend or give my medication to others.
8. I agree to **avoid all illegal** and recreational drugs (including alcohol) and will provide urine or blood specimens at the provider's request to monitor my compliance.
9. I agree to follow my provider's recommendations regarding the operation of **motor vehicles or heavy machinery** while taking this medication.
10. Refills will be made only during our regular office hours of **Monday-Thursday 8 a.m. – 5 p.m.** Refills will not be made at night, on weekends or during holidays. I am responsible for keeping track of my remaining medication, so that I can call for refills in advance. This way, I will not run out of medication. I understand that my prescription will not be ready until **48 hours** after I place my refill request.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Witness (optional):_____ Date: _____

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