Opioid Medication Agreement

Date: _____

Patient Name: _____

Patient Address: _____

Phone Number: _____

Introduction

This agreement outlines the guidelines for the safe use of opioid medications prescribed to you. It is important to follow these rules to ensure your safety and the effectiveness of the treatment.

Patient Responsibilities

- I agree to take the medication exactly as prescribed.
- I will not share my medication with anyone else.
- I will inform my healthcare provider of any other medications I am taking.
- I agree to store my medication in a safe place.
- I will attend all scheduled appointments and follow-up visits.

Healthcare Provider Responsibilities

- The provider will fully explain the risks and benefits of opioid medications.
- The provider will monitor my usage and adjust the treatment plan as necessary.
- The provider will provide guidance on safe disposal of unused medications.

Consequences of Non-Compliance

Failure to adhere to this agreement may result in:

- Discontinuation of opioid therapy.
- Referral to a specialist for substance abuse evaluation.

Signatures

By signing below, I acknowledge that I have read and understood this agreement.

Patient Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____