Opioid Prescription Monitoring Agreement

Date: _____

Patient Name: _____

Patient Address: _____

Patient Date of Birth: _____

Dear [Patient's Name],

This agreement outlines the terms and conditions under which opioid medications will be prescribed to you. It is designed to enhance your safety and well-being while managing your pain.

1. Agreement to Follow Prescription Instructions

You agree to take the medications exactly as prescribed by your healthcare provider. Any changes to dosage or frequency must be discussed with your provider.

2. Consent to Monitor

You consent to participate in regular monitoring of your prescription use, which may include drug screenings, pill counts, and reviews of your medical history.

3. Disclosure of Medication Use

You must inform your healthcare provider of all other medications you are taking, including over-the-counter drugs and herbal supplements.

4. Agreement to Safeguard Medications

You are responsible for keeping your medications secure and out of reach of others, including children.

5. Consequences of Agreement Violation

Failure to comply with this agreement may result in a discontinuation of prescribed opioids and further evaluation of your medical needs.

By signing below, you indicate that you have read and understood this agreement and agree to the terms outlined herein.

_____
Patient Signature

_____
Provider Signature

Thank you for your cooperation and commitment to safe medication use.

Sincerely,

[Provider's Name]
[Provider's Title]
[Practice Name]
[Contact Information]