Pain Medicine Contract

This contract has 4 parts.

Part 1  Tells you how and when to take your Pain medicine.

Part 2  Lists things you agree to do.

Part 3  Lists things that could happen if you do NOT do the things listed in Part 2.

Part 4  Sign the form.
        You and Dr. ______ must sign the form.

PART 1  MY PAIN MEDICINE

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Bedtime</th>
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PART 2  THINGS I AGREE TO DO

I Will:

- only get my Pain medicine from Dr. ______ office.
- take my Pain medicine as listed in Part 1.
- tell my other doctor(s) that I am taking Pain medicine.
- tell Dr. ______ about ALL of the medicines (over-the-counter, herbs, vitamins, those ordered by other doctors) I am taking.
- tell Dr. ______ about all of my health problems.
- allow Dr. ______ to talk with other doctors about my health problems.
- only ask for refills during an office visit (Monday to Friday from 8:00 am to 5:00 pm).
- tell Dr. ______ if I get Pain medicine from another doctor or emergency room.

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**I Will:**

- call Dr. ______ office at least 24 hours in advance if I need to cancel my appointment.

- keep my Pain medicine in a safe place AND away from children.

- get my Pain medicine from only one pharmacy:
  
  Address:
  
  Phone Number:

- bring all of my unused Pain medicine in their pharmacy bottles the next time I come to see Dr. ______. He/she may count the number of pills in my bottle(s).

- allow Dr. ____ to check my urine (pee) or blood to see what drugs I am taking.
I Will Not:

- share, sell or trade my Pain medicine with anyone.

- use someone else's Pain medicine(s).

- use any illegal drug (including marijuana, cocaine, crystal meth, or others).

- change how I take my Pain medicine(s) without asking Dr. ______.

- ask Dr. _____ for extra refills of my Pain medicine if I use up my supply before my next appointment.

- ask Dr. ______ for extra refills of my Pain medicine if I lose or misplace mine.
PART 4  SIGN THE FORM

Sign your name and write the date.

Sign your name

Date

Print your first name

Print your last name

Street    City    State    Zip Code

Dr. 
Doctor Name

Doctor Signature

Date

Created by:
Lorraine S. Wallace, Ph.D.