UCONN HEALTH Neag Comprehensive Cancer Center

(Patient Identification)

Opioid Therapy Agreement for Cancer-Associated Pain

Because other treatments have been unsuccessful or not appropriate to control your pain, your providers at the Neag Comprehensive Cancer Center (NCCC) have decided to prescribe you pain-reducing medications, known as opioids, to help manage your pain and improve your functional ability and quality of life. This is a serious decision because opioids present potentially serious risks. As your provider discussed with you, when used properly, these medications can help manage pain. If misused or abused, the potential risks include addiction, overdose and death. You must therefore agree to the following conditions to continue with this type of treatment.

Conditions:

1. I will not use illegal opioids, street drugs or abuse alcohol while taking opioids.
2. I will not take opioids prescribed for other people.
3. I will not be involved in the sale, illegal possession, diversion, or transport of opioids.
4. I agree to promptly undergo random drug testing, including testing for blood alcohol levels when my provider requests it.
5. I agree to undergo random pill counts for monitoring and safety at the direction of my provider.
6. I agree to obtain all my opioid prescriptions from NCCC providers only and to take medications only as prescribed by my provider.
7. I agree to schedule appointments in advance to ensure availability to be seen and follow-up every month with my provider regarding pain control.
8. I agree to being screened prior to initiation of therapy to assess risk of future addiction.
9. I agree to allow my provider in the NCCC to communicate with other providers treating me and any pharmacists involved in my care regarding my pain management.
10. It is my responsibility to secure all medications, particularly opioids, and I will take extra care to keep these medications out of reach of children.
11. I agree to contact the NCCC, as soon as possible, if an unavoidable emergency occurs requiring a prescription for opioids (ER visit or in-patient admission)
12. I understand that NO allowances will be made for lost prescriptions or medications.
13. I will immediately contact the police should my opioid medications be stolen.
14. I understand that NCCC will not permit you to refill a prescription for opioids when your opioids have been stolen, unless you provide NCCC with a copy of a police report and any additional information that we may require.
15. I understand the possible adverse effects and possible dependency associated with opioids.
16. I understand that my doctor is under no obligation to provide these medications and he/she reserves the right to discontinue these medications at any time if:
    a. I give away, sell or misuse the medications or use other peoples' medications
    b. I am non-compliant with any of the terms of this agreement
    c. I disrespect or harass clinic personnel
    d. I do not follow up regularly or as requested by my provider
    e. I refuse to comply with provider requests for a drug and/or alcohol screening test.

Today's Date: _____ **Expiration Date:** _____

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I have read this agreement, understand it and have all questions answered satisfactorily. I consent to the use of opioids under the terms outlined in this agreement valid for 1 year.

Printed Patient Name/Signature	Date
Printed Legal Guardian/Signature	Date
Printed Health Care Provider's Name/Signature	Date