Opioid prescription agreement

Patient name	
Prescriber name	

Please read the information below and complete and sign it once you are happy that you fully understand the information. Please ask your prescriber to explain anything that you do not understand.

I understand that I will receive pain management therapy (opioids) from:
…….. [insert prescriber name]
as part of the management plan to treat my pain condition. This medicine is only one item amongst a range of options for my care.

This medicine is intended to:

- Improve my level of mobility and ability to perform daily tasks.
- Improve my quality of life.
- Reduce (but not eliminate) my intensity of pain.

I have read and understand the potential side effects (provide patient information on opioids- Link here).	☐
I understand that this medication if misused can cause grave harm to myself or any other individual who may have access to it.	☐

Therefore I will;

Keep the medicine in a safe place and not share it with others.	☐
Take the medicine as it has been prescribed to me by: …….[insert prescriber name]	☐
If I require potent medication from another source I will inform my GP	☐
Agree not to take/use illegal drugs during this treatment	☐
Note that this medicine may be withdrawn if the intended benefits are not obtained.	☐

Patient name	
Patient signature	
Prescriber name	
Prescriber signature	
Date:	

Approved by APG: 20th September 2018 (review date: 20th September 2021)