**Treatment Agreement**

***NB: For new patients to the practice for whom opioids are to be continued or post discharge from acute hospital care including A&E attendance – must be completed prior to prescribing first practice generated prescription***

**Patient Name**: ……………………………….…… NHS number: …………………………….

**Condition(s) being managed with opioids:**

**New opioid being commenced (including dose range and interval):**

**Agreed objectives for success of opioid trial:**

* Desired improvement in function (return to work, ability to pursue interest, general mobility, night-time sleep etc.)
* 30% reduction in pain (as documented on the pain diary)

***If there is neither the agreed reduction in pain intensity nor the desired improvement in function, the opioid trial is not successful, and the opioid should be discontinued.***

**Period before next mandatory review:**

(2-4 weeks if pain constant; longer if intermittent disabling flare ups of pain)

**Patient Declaration**

In signing this agreement, I agree to the following conditions regarding his/her treatment and the prescribing of an opioid medication:

1. I have read the “[Thinking About Opioid Treatment For Pain](https://fpm.ac.uk/opioids-aware-information-patients/thinking-about-opioid-treatment-pain)” and “[Taking Opioids For Pain](https://fpm.ac.uk/opioids-aware-information-patients/taking-opioids-pain)” information leaflets and I will tell my GP if I experience on-going/intolerable side effects.
2. My Prescriber is responsible for prescribing a safe and effective dose of the opioid medication. My Prescriber will control my dose, perhaps with advice from one or more hospital specialists in a condition relevant to my pain.
3. I will follow the directions given to me by my Prescriber; I will not increase my dose beyond that specified and will discuss any changes in my dose with my Prescriber.
4. I will not use any other opioids in addition to those prescribed by my Prescriber.
5. I will only obtain my opioid medication from my Prescriber.
6. I understand that no early prescriptions will be provided*.*
7. Any evidence of unsafe use such as: drug hoarding, acquisition of any opioid medication or other pain medication from other sources, uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the agreement and withdrawal of opioids.
8. I am responsible for the security of my opioid medication at home. Lost, misplaced or stolen medication or prescriptions for opioid medicines may not be replaced. In the event that opioid medication is stolen, I will report this to the police.
9. I am aware that giving my opioid medication to other people is illegal and could be dangerous to them.
10. I understand that if my level of activity has not improved, I do not show a significant reduction in my pain, or if I do not comply with any of the conditions listed above my opioid prescription may be changed or stopped.

**Patient’s Signature**: ……………………………………………………. Date: …………………………. **Prescriber’s Signature**: ……...…………………………………………. Date: ………………………….