Renfrew Medical Associates Patient Agreement for Opioid / Benzodiazepine Therapy

1. I, _____ agree that Dr. _____ will be the only physician prescribing Opioid/Benzodiazepine Medication for me and that I will obtain all of my prescriptions for Opioid/Benzodiazepine Medication at one pharmacy.
2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioid / benzodiazepine without first discussing it with my physician.
3. I will not request earlier prescription refills.
4. I will attend all reasonable appointments, treatments and consultations as requested by my physician. I agree to other pain consultations/management strategies as necessary.
5. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid / benzodiazepine therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
6. I understand that using long-term opioids / benzodiazepine medications may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to symptoms of opioid / benzodiazepine withdrawal which may include, but needn't be limited to, agitation, sweating, or nausea. I agree to seek medical attention if these or other symptoms occur.
7. I understand that there is a risk that I may become addicted to the opioids / benzodiazepine mediations that I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.
8. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid / benzodiazepine therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
9. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.
10. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.
11. I consent to open communication between my doctor and any other health care professionals involved in the management of the condition for which the opioid / benzodiazepine medication is being prescribed, such as pharmacists, other doctors, emergency departments, etc.
12. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid / benzodiazepine medications for me.

Date: _____

_____ _____

(Signature - Patient) (Signature Physician)

Adapted from www.PainCare.ca &
http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html