



OFFENDER I.D. DATA:

(Name, DOC#, DOB)

## CHRONIC PAIN MANAGEMENT AGREEMENT

DATE	FACILITY/UNIT
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### PAIN MANAGEMENT TREATMENT PLAN

<b>Treatment Indication:</b>	
<b>Physical Goals:</b>	
<b>Educational Goals:</b>	
<b>Mental Health Goals:</b>	
<b>CD Program Goals:</b>	
<b>Measurable Objectives:</b>	Manage ADLs:
	Activity log:
	Engage in programming/work:
	Engage in exercise/hobbies:
	Exercise log:
	Utilization of healthcare resources:
	Pain intensity/physical activity scores:
	Compliance with prescriptions:
	Compliance with other treatments (heat, ice, stretching, strengthening, use of DME, physical therapy regime):
	Third-party observations:
Urinalysis:	
<b>Planned Diagnostics:</b>	
<b>Drugs/Dose:</b>	
<b>Next visit:</b>	
<b>First Quarterly Visit:</b>	
<b>Exacerbation Mgmt:</b>	

Plan, including drug effects and complications if plan not followed, explained to patient's satisfaction

Patient agrees to plan:  Yes  No

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PATIENT INITIALS

### OPIOID TREATMENT CONSENT

**I understand that** my practitioner is prescribing opioid (narcotic) medication to assist me with managing my chronic pain that has not responded to other treatments and it must be effective in assisting me to function better. Opioids will not completely eliminate pain but will help me tolerate it. If my activity or general function gets worse or does not improve, the medication may be changed or stopped. There are side effects and risks from using from opioids, but they can be mostly controlled or minimized. I may develop addiction. If I stop taking my medication abruptly, I will experience a withdrawal reaction. Overdose from opioids is possible but uncommon. I should be aware of the signs of overdose. The risks, side effects and benefits of this treatment have been explained to my satisfaction. I have asked all the questions I wanted. I understood all the answers given. I wish to proceed with, and agree to, the treatment plan on the reverse of this page. I received a printed copy of both sides of this document and any other information I requested. I now agree to **all** of the following conditions. **If I fail to follow any or all of the conditions below, opioids (narcotics) will be stopped.**



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**I will:**

- Remember my responsibility to be truthful and express my concerns to my practitioner
- Notify my chemical dependency counselor, self-help sponsor, or family members that I am receiving prescribed narcotics for pain **if I have ever had a drug abuse problem** so that they may assist me in treatment and/or relapse prevention
- Request information or clarification about any treatment that I do not understand
- Cooperate with the treatment plan discussed and follow my Personal Care Plan
- Actively participate in any other treatments I am asked to complete (hot packs, cold packs, modified activity, physical therapy, daily exercise, endurance training, flexibility exercises, using medical devices, etc.) and keep a record of my activities and pain levels
- Bring my activity/pain level log to each appointment
- Agree to taper or stop medication as my functioning improves or if other effective treatment becomes available
- Take my medications exactly as prescribed and will report any attempt by others to interfere with my medication
- Keep all my clinic appointments
- Provide a urine specimen for testing when requested

**I will NOT:**

- Request a specific medication or dose
- Ask any practitioner other than my primary care practitioner for narcotics
- Cheek, chew, save up, trade, hoard, or sell opioids
- Take any other drugs or over the counter medication except as prescribed or recommended by my DOC practitioner

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PATIENT SIGNATURE

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PRACTITIONER SIGNATURE AND STAMP

*State law (RCW 70.02) and/or federal regulations (42 CFR Part 2) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.*