DEBORAH WESTERGAARD M.D.
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Pain Management Agreement for Prescriptions

This agreement applies to all prescriptions including opioids

I, _____ understand that I must comply with the following rules of the Pain Clinic in receiving opioids.

1. I will use the opioid pain medications only as directed.
2. I will **NOT** increase my opioid usage, nor abruptly stop my opioid usage, without a pain clinic doctor's permission.
3. I will **NOT** receive opioid medication outside of Dr. Westergaard's pain clinic.
4. I will receive opioid ONLY at scheduled pain clinic visits. I will **NOT** receive opioid pain medications from the clinic by mail, or over the phone.
5. I will call the pain center when I need to schedule an urgent appointment, or I am having side effects or having problems from the opioids.
6. **I may be asked to submit to drug testing during opioid therapy.** If my drug testing results are unsatisfactory, I understand that my doctor may decrease or discontinue my opioid therapy.
7. I will **NOT** use illegal drugs with my opioid medications, sell my pain medications, allow others to use my medications, alter my medication prescriptions, use my in unintended ways, use alcohol, or allow my medications to become damaged.
8. I will file a local police reports if my opioids are lost or stolen before they are replaced at the pain center. (Opioids are controlled substances, US Drug Enforcement Administration).
9. I will notify my doctor if I am considering or become pregnant.
10. I understand that opioids can impair motor skills. Caution is urged when driving and operating heavy equipment.
11. If it is felt that I am not complying with the opioid agreement, my doctor may elect to decrease my opioids, or have addictions services assist my care.
12. Any changes to medications or changes to directions will not be addressed over the phone. This will be discussed during an office visit with Dr. Westergaard.

I understand that my doctor may also choose to discontinue my opioid therapy if he or she believes that my pain is not improving on opioids, my use of opioids is escalating, or I am experiencing unacceptable side effects.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date

Pharmacy Information:

Pharmacy Name:_____

Address: _____

Phone:_____ Fax:_____