Pain Treatment with Opioid Medications: Chronic Pain Treatment Agreement*

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____ My pet is being prescribed an opiod medication to be used in conjunction with other medications to help manage chronic pain associated with _____.

_____ If the medication is discontinued or no longer needed, I understand I am responsible for discarding the medication(s) properly. The appropriate way to dispose of controlled medications is to squirt liquid medications into the sink or toilet and rinse thoroughly. Pills can be mixed with kitty litter or used coffee grounds and thrown away. All needles must also be disposed of properly via a sharps container.

_____ I will keep the medicine safe, secure and out of the reach of children and unauthorized adults. If the medicine is lost or stolen or used prior to the anticipated date, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will give my pet the medication as instructed and not change the way I give it without first talking to the doctor or other member of the treatment team.

_____/ NA I understand how to give a subcutaneous (under the skin) injection to my pet. If I am unfamiliar with the technique, I will ask for additional instruction and/or demonstration. A video describing the technique can be found here: https://www.youtube.com/watch?v=JrC7VHd-uro.

_____ I will not sell this medicine or share it with others. I understand that if I do, my pet's treatment will be stopped.

_____ I will tell the doctor all other medicines that I give my pet, and let him/her know right away if I have a prescription for a new medicine for my pet.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

_____ I understand that refills will be made only during regular office hours—Monday through Friday, 8AM - 5 PM. I must call at least one (1) working days ahead (M-F) to ask for a refill of my pet's medicine.

_____ I will only use one pharmacy to get my pet's controlled medications. Pharmacy name/phone: _____

Client First and Last Name (Printed): _____ Client Signature: _____

Client Date of Birth (required for Virginia Prescription Monitoring Program): _____

Pet's name: _____ Printed Date: _____

*Adapted from the American Academy of Pain Medicine