Space for Practice logo

# Opioid Agreement

Name: ..........................................................................................................................................................

Address: ......................................................................................................................................................

Name and dose of medicine: .............................................................................. Year commenced: .......................................

Reason for medicine (source of pain): ..........................................................................................................................

**This is an agreement between** .......... *<insert Doctor's name>* .......... **and me to continue a morphine-like medicine for my pain.**

- ☐ **I agree to this contract for 12 months.**
- ☐ **I agree that the decision to cease or continue this medication remains with the doctor.**
- ☐ **I understand that I may experience the following SIDE EFFECTS:**

| SIDE EFFECTS | |
|---|---|
| Tolerance:<br>• I may need higher doses and more often | Constipation |
| My pain may worsen over time | Nausea or vomiting |
| Physical dependence:<br>• If this medicine is stopped suddenly, I may experience diarrhoea, stomach cramps, goose bumps and runny nose | Drowsiness, confusion, lethargy or clouded thinking<br>• driving may be affected |
| Psychological Dependence:<br>• I may experience a strong desire to take more of this medicine<br>• I may experience an uncontrollable need to seek out and use this drug, despite harmful consequences | Hormone and sexual function changes:<br>• Cause impotence or lose my sex drive<br>• Changes in my menstrual periods<br>• Osteoporosis |
| Loss of balance | Depression and anxiety |
| Slowed breathing | Itchy skin |
| Problems with my teeth and dry mouth | Problems with sleeping and worsened sleep apnoea |
| Hallucinations | Weight gain and change in appetite |
| If pregnant – my baby may become dependent and may experience withdrawal when born | An overdose if too much is taken or used with other medicines, alcohol or cannabis<br>• slowed thinking & breathing<br>• speech slurs<br>• staggering when walking |

**I agree also:**

- ☐ that I will see only .......... *<insert name of primary GP>* .......... for ongoing prescriptions of this medicine,

  or .......... *<insert name of secondary GP>* .......... from .......... *<insert name of medical practice>* ..........

  if this has been arranged in advance by my doctor (an appointment with this doctor may be required);
- ☐ that I will not use any more of the medicine than is prescribed for me;
- ☐ that my own or any other doctor will not be able to give me extra medicine if mine is lost, stolen or runs out early;
- ☐ I will not give my medicine to anybody else;
- ☐ to a regular review of this medicine for its benefits and unwanted effects.
- ☐ not to use it for any other purpose than why it has been originally prescribed;
- ☐ that if I do not abide by any of these conditions, my doctor may no longer prescribe this medicine for me

What I am hoping to be able to do by taking this medicine: ..........................................................................................

Signature .................................................................................................................. Date: ..................................................

*Resource adapted from Woonona Medical Practice*