Acute Pain Controlled Medication Patient Contract

Date: ___________________

Goals of treatment:
To achieve my pain rating and activity goals.
  Goal 1: ________________________________
  Goal 2: ________________________________
To relieve my pain without causing sedation.
To keep me from experiencing withdrawal symptoms.
Other: ________________________________

Patient and staff responsibilities:

❖ I will use the pain rating scale to report pain to the staff.
❖ The staff will accept and respect my reports of pain as the best indicator of how much pain I have.
❖ The staff will be responsible for providing as much analgesia as necessary to relieve my pain, unless it would endanger my health.
❖ I will receive my analgesics from a single provider only, __________________. I will not seek medication from a dentist or the emergency room without this Doctor’s knowledge.
❖ I will not sell, trade, or give my pain medication to others.
❖ I will not engage in illegal activities to obtain pain medication.
❖ I will be responsible for keeping my medication out of the reach of children, pets, and others and for not misplacing or losing it.
❖ I understand that taking my medication when using alcohol or other drugs could be extremely dangerous to my health.
❖ I have received, read, and understand the Acute Pain Patient Information document.

We mutually agree to the above.

____________________________
Patient

____________________________
Physician