Space for Practice logo

Opioid Agreement - Trial

Name: .....

Address: .....

Name and dose of medicine: ..... Date commenced: / /

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

This is an agreement between *<insert Doctor's name>* **..... and me for a trial of starting or for continuing a morphine-like medicine for my pain.**

- ☐ **I agree to this trial for .....weeks.**
- ☐ **At the end of that period, I agree that if the medicine has not provided the benefit that we have aimed for, then it will be slowly withdrawn and ceased.**
- ☐ **I agree that the decision to cease or continue this trial remains with the doctor.**
- ☐ **I understand that I may experience the following SIDE EFFECTS:**

SIDE EFFECTS	
Tolerance: • I may need higher doses and more often	Constipation
My pain may worsen over time	Nausea or vomiting
Physical dependence: • If this medicine is stopped suddenly, I may experience diarrhoea, stomach cramps, goose bumps and runny nose	Drowsiness, confusion, lethargy or clouded thinking • driving may be affected
Psychological Dependence: • I may experience a strong desire to take more of this medicine • I may experience an uncontrollable need to seek out and use this drug, despite harmful consequences	Hormone and sexual function changes: • Cause impotence or lose my sex drive • Changes in my menstrual periods • 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 • slowed thinking & breathing • speech slurs • 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;
- ☐ 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