Camden PCT and UCLH Palliative Care Team
CONTROLLED MEDICATION AGREEMENT

I _____agree to participate in a pain management programme with the Palliative Care Team. I may be provided with controlled medications such as opioids, for the treatment of _____ pain only while actively participating in the program, if I adhere to the following regulations:

1. **Risks:** I understand that some risks associated with long-tem controlled medications are dependence, addiction, tolerance, constipation, sleep changes, potential for increased pain, risk to unborn children, changes in appetite, coordination, sexual desire and sexual performance. Stopping such medications suddenly can cause withdrawal. Combination with other drugs (including alcohol and nicotine) can lead to breathing difficulties and other problems. I will notify the Palliative Care Team if I experience any of these
conditions.

2. **Treatment Plan:** I agree to adhere to the treatment plan discussed with me regarding controlled medication including; type of drug, method of drug delivery, frequency, and dosage.

3. **Prescription Source:** I will receive controlled substances for the treatment of pain only from _____. Should anything change suddenly and controlled medicaton is provided by another source, I will notify the prescribing team of this as soon as possible.

4. **Pharmacy:** I will use only one pharmacy _____ _____for controlled medication prescriptions. If I need to change my pharmacy, I will notify the prescribing team.

5. **Safety of Medications:** I understand that I am solely responsible for the safe keeping of my medication.
In the event that it is lost, stolen, destroyed or used other that than prescribed, the prescribing team **will not** replace the prescription until the due date of my next refill. To aid with the signs and symptoms that I may experience due to withdrawal, the Palliative Care Team will contact the substance abuse team or I will be required to provide a police report on or before my next appointment.

6. **Discontinued Therapy:** Controlled medication may be discontinued if it fails to achieve set goals. I agree to see the drugs liaison nurse if appropriate. Discharge from the Palliative Care Team will occur if I obtain multiple controlled medications from multiple practitioners, fill prescription at multiple pharmacies, sell or give away or otherwise divert the medication from its intended use, or alter prescriptions. Patients that miss three (3) consecutive appointments (cancellation or no show) will be discharged to the care of their GP.

7. **Testing:** I understand that my urine and/or blood my be tested at any time for levels of the substances in my system. I may be requested to bring in my medication for the Palliative Care Team to inspect.

8. **Appointments:** If I am on stable doses of controlled medication, I still need to schedule and keep appointments with the Palliative Care Team to assure that I do not run out of my medications.

9. **Consent:** I give my consent for the Palliative Care Team to speak with my pharmacist and other physicians to exchange pertinent information regarding my medical condition.

10. **GP:** I understand that I must have a GP while being treated by the Palliative Care Team. If I change GP's I must notify the Palliative Care Team and provide the name, address and phone number of my current GP. I understand that the Palliative Care Team will communicate with my GP to provide updates of my treatment plan and that I will be returned to the care of my GP at the discretion of the Palliative Care Team.

I have been provided with a copy of this agreement and understand that I may discuss any questions or concerns about the contents with my physician at any time.

Signature of Patient _____

Date:_____

Signature of Palliative Care Team_____

Review date: _____