Twin Cities Pain Clinic

7235 Ohms Ln, Edina, MN 55439

Tel: (952) 841-2345
Fax: (952) 841-2346
twincitiespainclinic.com

Suboxone Medication Agreement

Suboxone is a controlled medication. These medications are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and your provider by establishing guidelines, within the laws, for proper controlled substance use.

Name:_____ DOB:_____

1. The medication must be safe and effective to help me function better and to keep me off other opioid medications. I understand that suboxone has been associated with treating opioid addition and dependence but may also help control chronic pain.
2. I will not use alcohol or illegal/recreational drugs, including marijuana. I understand that mixing suboxone with other medications, especially other opioids, benzodiazepines (Xanax, Ativan, Valium, Klonopin, etc), alcohol, or other street drugs can have extremely dangerous consequences, including death.
3. I will participate in other treatments (physical therapy, psychology, etc.) that my provider recommends.
4. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my provider's approval. I understand if I overtake my medication there may be a period of time where I do not have them, and I may experience withdrawal symptoms. I understand that stopping suboxone suddenly can result in these withdrawal symptoms.
5. I will bring all suboxone tablets/films to every office visit in its original container. I will return for an appointment BEFORE running out of medication. I understand a medication count will be done at each office visit.
6. I will keep regular appointments as determined by my provider. I agree that prescription refills or changes will be made only at the time of an office visit. No refills or changes will be available during evenings or weekends.
7. One provider – I will not obtain any other pain medications outside of TCPC without informing my treating TCPC provider. It is my responsibility to notify any outside providers that I receive suboxone from TCPC. Acute injuries/conditions (ie. fractures, dental procedures) and scheduled surgeries require approval from TCPC prior to receiving pain medication, as suboxone can interfere with the medications that may be used for these procedures/treatments. It is my responsibility to notify TCPC and obtain this approval BEFORE accepting any pain medication and/or prescriptions for pain medication.

Revised: 4/26/17

8. One pharmacy – I will choose one pharmacy where all my prescriptions will be filled. Pharmacy:_____, Location:_____, Phone: _____
9. I will safeguard my medication/prescriptions from loss, theft, destruction, or unintentional use by others. I understand these will not be replaced. Early refills will not be permitted.
10. I will not share my medication with anyone or use medications prescribed to other people. I will provide urine and blood specimens at the provider's request to monitor my compliance.
11. I understand that driving while under the influence of any substance which impairs my driving ability (including suboxone which is considered an opioid medication), may result in DUI charges.
12. I understand that my health information may be exchanged with other providers, pharmacists, and drug/law enforcement agencies to assist in my treatment and maintain accountability. I understand my provider will be verifying my prescription history through the Prescription Monitoring Program.
13. I understand that clinic staff (nurses, receptionists, lab staff, etc.) are very important in my success with this treatment plan. I will treat them respectfully and abide by their enforcement of this agreement.
14. I understand that if I break this agreement, my provider will stop prescribing these medications to me. In this case, my provider will taper off the medication over a period of several days, and/or a chemical dependency program will be recommended.
15. If there is an urgent issue that cannot wait until the next business day, I will call (612) 999-5683 to leave a message for the on-call provider. If there is a life-threatening emergency, I will call 911.

I have read this agreement and understand and accept all its terms. I have been provided with a copy of this document. I have read and signed TCPC's "Consent for Chronic Opioid Therapy".

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

Revised: 4/26/17

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: _____ Date: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Devices used for Dressing (button hook, zipper pull, etc.)
☐ Built up or special utensils
☐ Crutches
☐ Cane
☐ Wheelchair
☐ Special or built up chair
☐ Walker

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Raised toilet seat
☐ Bathtub bar
☐ Long-handled appliances for reach
☐ Bathtub seat
☐ Long-handled appliances in bathroom
☐ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene
☐ Reach
☐ Gripping and opening things
☐ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
☐	☐	☐	☐	☐

Your PAIN: How much pain have you had IN THE PAST WEEK?
On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.
