**This is for you to adapt for your patient(s). Please ensure that you customise the text highlighted in yellow so that the information is appropriate. Please also ensure that once you have made your amendments, any important information isn’t split across two pages, or that an instruction to continue on to a second page is added.**

**Prescription agreement**

|  |  |
| --- | --- |
| **Patient name** | [add patient name] |
| **Prescriber name** | [add prescriber name] |

Please read the information below and complete and sign it once you are happy that you fully understand the information. Please ask your prescriber to explain anything that you do not understand.

I understand that l will receive sleeping tablets for the short term treatment of sleep / pain management therapy (opioids/pregabalin/gabapentin) from [insert prescriber name] as part of the management plan to treat my pain condition. This medicine is only one item amongst a range of options for my care.

This medicine is intended to [delete as appropriate]:

* Improve my sleep for short periods of time ..if
* Improve my level of mobility and ability to perform daily tasks.
* Improve my quality of life.
* Reduce (but not eliminate) my intensity of pain.

|  |  |
| --- | --- |
| I have read and understand the potential side effects (provide attachment x for patient). | [ ]  |
| I understand that if this medication is misused it can cause harm to myself or any other individual who may have access to it. | [ ]  |

Therefore I will:

|  |  |
| --- | --- |
| Keep the medicine in a safe place and not share it with others. | [ ]  |
| Take the medicine as it has been prescribed to me by [insert prescriber name] and not to take more than the prescribed dose and quantity.  | [ ]  |
| I understand that I will only order my medication at agreed intervals and not weeks before my supply finishes. | [ ]  |
| I understand that the medication will be reviewed at frequent intervals and that I need to ensure that I can be available for review (face to face or telephone). | [ ]  |
| I understand that my medication may be reduced and stopped when the pain condition resolves. | [ ]  |
| If I aquire any medication from another source I will inform my GP. | [ ]  |
| I agree not to take/use illegal drugs during this treatment. | [ ]  |
| Note that this medicine may be withdrawn if the intended benefits are not obtained. | [ ]  |

|  |  |
| --- | --- |
| **Patient name** | [add patient name] |
| **Patient signature** |  |

|  |  |
| --- | --- |
| **Prescriber name** | [add patient name] |
| **Prescriber signature** |  |