Opioid analgesia for acute spinal pain

TREATMENT AGREEMENT

In the OPAL study you are randomly allocated to receive an opioid analgesic or a placebo as the study medication. This document provides information about your overall pain management plan and seeks your written approval to proceed with the treatment.

Patient name:
GP name:
GP contact details:

Treatment commencement date:	____ / ____ / ____
Planned duration of treatment (max 6 weeks):	☐ 6 weeks ☐ ____ weeks
Next GP review:	____ / ____ / ____ (the recommended frequency is weekly)

Goals of treatment

Goals (e.g. walk 3 times a week for 30 min)	**Review date**	**Comments**
1. Reduce my average pain score from __/10 to __/10		
2.		
3.		
4.		
5.		

Other ways to help my pain:

1. Staying active and avoiding bed rest
2. _____
3. _____
4. _____
5. Treatments from other health professionals: ☐ physiotherapist ☐ chiropractor ☐ Other: _____

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If pain gets worse I can try:

Non-medicine strategies	Medicines

Please remember:

1. Only one doctor is responsible for prescribing your study medication. Arrangements can be made for an alternate prescriber to cover the absence of your doctor if needed.
2. Using the same pharmacy to re-fill your study prescription is a requirement of the OPAL study.
3. We will not give early prescriptions or replace lost prescriptions or medication, therefore you need to keep your study medication secure and take the dose as prescribed.
4. If you run out of your study medication early you may develop withdrawal symptoms which can be uncomfortable but are not life threatening.
5. If your behaviour suggests a problem with the misuse of medicines or addiction then your doctor will consider tapering and ceasing the study medication or referral to a Drug and Alcohol service. Problem behaviours include giving your medication to others, use of your medication in a non-prescribed way, excessive use of other medications (including alcohol and illicit drugs), repeated loss of medication, visiting multiple doctors to obtain medicines (doctor shopping) and worsening function at home or work.

Agreement

I have read the information provided and agree to this plan.

Patient signature: _____ **Date:** ____ / ____ / ____

GP signature: _____ **Date:** ____ / ____ / ____

Acknowledgements: adapted from 'My Pain Management Plan', National Pain Prescribing Service (NPS), and 'Opioid Treatment Agreement', Hunter New England Local Health District.

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