Approved by South East London APC
March 2019
Review Date: March 2021

South East London Pharmacological Management of Adult Non-Cancer Chronic Pain in Primary care

Pain treatment pathway for non-cancer chronic pain ≥ 3 months duration in adults in primary care[1,2,3,4]

Key Principles

- Goal setting: Inform patients that pain may be resistant to medication and complete relief of symptoms is not a goal of therapy; 30-50% pain relief may only be obtained.[2, 3] Treatment success is demonstrated by improvement in function. Improved sleep would also be a reasonable outcome.[2, 3]
- Progressing through the steps below does not guarantee increased benefit or better pain relief. Medication does not always work; stop medicines that are not working.
- Using analgesics with different modes of action can produce a synergistic effect, resulting in better pain relief at lower doses.
- 3-monthly medication reviews are recommended for all patients taking regular analgesics; prioritise patients taking opioids or gabapentinoids.
- The focus of pain management should not be on medication alone (the least changeable aspects of long-term pain). At each review consider non-pharmacological treatment **(see appendix A)** to improve physical, psychological health. Examples include maintaining fitness, weight loss, pacing activities, mind-body techniques, IAPT and a generally healthy lifestyle are important.[2, 3] Consider screening for common mental health problems that may relate to pain. [2, 3]

STEP 1

Assessment and non-pharmacological strategies

- Assess pain type and severity (appendix B).
- Discuss previous interventions, including over-the counter medication and illicit drug use.
- For osteoarthritis pain consider NICE management strategy (appendix C)
- Exclude red flags (appendix D).
- Consider possibility of neuropathic/mixed pain: refer to **SEL Neuropathic Pain Guidance**
- Establish expectations and agreed goals. **Complete relief of symptoms is not a goal** of therapy.
- Discuss **non pharmacological strategies** (especially for mechanical chronic pain) and **empower patients** to make decisions about their pain management through signposting them to patient-focused resources **(appendix E)**
- As this guideline covers **chronic** pain management, the self-care initiative recommendations (OTC) do not apply.

STEP 2

Regular Paracetamol 1g QDS
(1g TDS if < 50 kg, malnourished, renal or hepatic impairment)
Paracetamol alone is not recommended in management for low back pain[3]
+ / OR
Ibuprofen (400 mg TDS, max 2.4g daily) OR **Naproxen** (250-500mg BD, max 1.25g daily) **when required**
(Trial NSAIDs for a short period, then if used regularly, will need to incorporate breaks).
See Appendix F on NSAID and gastro-protection and cardiovascular risk

CONSIDER OPIOID RISK TOOL (ORT) BEFORE CONTINUING TO STEP 3
To assess the risk of opioid abuse potential in primary care settings. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations. ***See appendix H***

STEP 3

CODEINE 30-60mg (upto QDS) PRN
(Consider **Co-Codamol** for those with adherence issues/ not managing well with multiple tablets and regimens)
(Incorporate breaks to avoid tolerance)
OR (*If patients do not respond to codeine i.e.* no improvement in pain or function and/ or intolerant)
DIHYDROCODEINE 30mg (upto QDS) PRN *(max 180mg daily)*
(Incorporate breaks to avoid tolerance, *less constipating but nausea/vomiting are more prominent).*
Consider co-prescribing laxatives and/or anti-emetics and inform patient of DVLA driving advice
REVIEW TREATMENT AFTER 3 MONTHS

Ineffective or not tolerated: STOP Step 3 opioid AND consider step 4
OPIOIDS ARE OF LIMITED USE FOR THE TREATMENT OF CHRONIC LONG TERM PAIN, THE RISK OF HARM INCREASES SUBSTANTIALLY AT DOSES ABOVE ORAL MORPHINE EQUIVALENT OF 120mg/ DAY, AND THERE IS NO INCREASED BENEFIT.[3]

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STEP 4

Complete OPIOID RISK TOOL (see appendix H)

OPTIMISE NON-OPIOID TREATMENT AND NON-PHARMACOLOGICAL STRATEGIES

Assess risk for long term opioid treatment: History of mental health, substance abuse, overdose, concurrent benzodiazepine/ gabapentanoid use, sleep disorders, and breathing.

LOW RISK (0 to 3)	MODERATE RISK (4 TO 7)	HIGH RISK (≥ 8)
Manage in primary care. Consider trial of other opioids.	Not a contraindication to opioids but will need more monitoring (earlier review, limited prescriptions).	Refer to pain specialist.

Trial of other opioids, discuss with the patient:

- Risks and benefit of long term opioid therapy ***(appendix A)***.
- Provide: **Taking opioids for pain leaflet** and other resources including opioid side-effects.
- **Driving advice**: Some analgesic drugs can cause drowsiness and impaired judgment and patients should be advised not to drive if they feel unfit to do so. It is an offence to drive with certain controlled drugs above specified limits in the blood. **It is the patients' responsibility to notify the DVLA**.
- **Agree and document realistic goals of trial** e.g. 30-50% reduction in pain intensity, specific functional improvement/improvement in sleep. Complete a patient agreement form (appendix K).
- **Keep a pain diary,** twice daily reporting of pain intensity, comments on sleep and activity levels, doses taken and side effects. *See example diary in appendix G.*
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be **kept low and use is intermittent.**
- See appendix I on information on step 4 opioid trial (other than codeine/ dihydrocodeine).

Step 4 Choice for opioid trial

a. Tramadol immediate release (intermittent) e.g. Tramadol 50mg upto QDS PRN, ***OR***
b. Morphine immediate release e.g. Initially Sevredol 10mg upto qds (PRN) , ***OR***
c. Buprenorphine patches (if oral analgesia is not an option, or or topical is preferred should be reserved for stable pain)

Table 1: Equivalent doses to oral morphine

	Potency ratio with oral morphine	Equivalent dose to 10mg oral morphine
Codeine phosphate	0.1	100mg
Dihydrocodeine	0.1	100mg
Morphine	1	10mg
Tramadol	0.15	67mg
Oxycodone	2	5mg

See Appendix J for more on patches

Use LOWEST EFFECTIVE dose of immediate-release opioid preparation. If meaningful pain relief is not achieved from opioid **within 4 weeks**, unlikely to gain long-term benefit.[2, 3, 7]

If intermittent flare ups, trial for long enough to observe effects on 2-3 episodes of increased pain. **Do not prescribe more than 50mg morphine equivalent daily dose (MEDD) until there is specialist input.**[7, 12, 13] **DO NOT initiate Fentanyl (Amber 2) or Oxycodone (Amber 1) in primary care.**

When to refer to pain specialist:

Clinicians should consider referral or advice and guidance, at any stage as it is important to deal with pain early.
Patients with complex pain and psychosocial problems.
Patients at high risk of abuse and pain is not managed with optimal doses of non-opioids and non-pharmacological management
Patients who do not obtain meaningful pain relief with 50mg MEDD.

Trial Successful (and safe to continue)

Monitor: analgesia, activity, adverse effects, mood, sleep and aberrant behaviors
Once dose and symptoms are stable, and no additional clinical concerns, **review 3-6 monthly.**
Consider tapering dose down at reviews.
A successful short-term opioid trial does not predict long-term efficacy.

Trial unsuccessful

The medicine should be tapered and stopped within one week.

Not recommended for initiating in primary care

Nefopam - no more potent than NSAIDs but is commonly associated with adverse drug reactions such as urinary retention and is toxic in overdose. Assess whether potential benefits outweigh risks in individual patients.[7, 8]
Oxycodone HCl capsules, m/r tablets, liquid – for restricted use when morphine is not tolerated or contra-indicated. Under specialist advice.
Tapentadol m/r tablets - Initiation and titration is restricted to pain consultants only. Care can be transferred to the patient's GP (with a care plan) once on a stable dose.[11]
Fentanyl IR – Restricted for palliative care only.[11]
Lidocaine plasters – *restricted for* neuropathic pain specialists.

Non-Formulary

Not approved for use in pain management in SEL

- ***Tramadol HCl modified-release***
- ***Targinact***
- ***Tramacet***

Appendix A: Non-Pharmacological management

Resources sheet

This is a list of books, CDs and other resources to help your patient to manage their pain well.
https://livewellwithpain.co.uk/resources/resources-for-patients/resources-sheet/

For more information on what services are available in your local area, check with your local commissioners and community pharmacies.

Appendix B: Pain Assessment Tool[16]

A large number of pain assessment tools exist and their content varies. These examples are not exhaustive and alternative assessment methods may be used.

Pain severity has historically been assessed using a basic scale as outlined below. The patient is asked to rate their pain between 0-10, with 0 representing no pain and 10 representing the worst pain imaginable. The pain scores broadly equate to mild, moderate or severe pain and can be cross-referenced with pain management flow chart (page 1-2) and used to guide analgesic choice. However, because pain has complex mechanisms, different approaches to pain assessment including the use of more in depth multidimensional assessment tools should be considered, these provide a fuller assessment of the patients pain and treatment effectiveness.

Figure 2. Pain Rating Scale

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild pain			Moderate pain			Severe Pain			Worst pain

Multidimensional pain assessment tools, measure the intensity, nature, and location of pain, and in some cases, the impact that pain is having on a patient's activity or mood; multidimensional scales are useful in complex or chronic pain. Examples are:

- The Pain Rating Scale produced by the British Pain Society and Brief Pain inventory which allow patients to rate the severity of their pain and the degree to which their pain interferes with common dimensions of feeling and function.
- McGill pain Questionnaire can be used to evaluate a **person experiencing significant pain**. It can be used to **monitor the pain over time** and to determine the effectiveness of any intervention.

For patients who do not speak English as their first language: The British Pain Society has produced a series of pain scales in multiple languages. These can be downloaded and printed for free from their website.

For patients with poor cognitive function: Observed non-verbal pain assessment scales may be needed. These require patient to be observed at rest, on movement and for behavioral changes that may indicate pain. Therefore appropriate use will necessitate input from carers /family and variable amounts of training. Further guidance on the assessment of pain in older people has been produced by the British Pain Society in collaboration with the British Geriatrics Society and Royal College of Physicians. **Examples are:**
Checklist of non-verbal pain indicators (CNPI) - This considers vocalization, facial expression, stimulus, friction, agitation and verbal complaints. These are marked as "present" or "absent" under two conditions: movement and at rest.

Doloplus 2. This assesses the progression of the pain experience and consists of 10 items, divided into three groups, namely, somatic reaction, psychometric reaction and psychosocial reaction.

Appendix C: Management of osteoarthritis

Osteoarthritis (NICE CG177)

CORE treatment:

1. ***Offer accurate verbal and written*** information to enhance understanding of the condition and its management, and to counter misconceptions, such as that it inevitably progresses and cannot be treated. Ensure that information sharing is an ongoing, integral part of the management plan rather than a single event at time of presentation.
2. ***Activity and exercise*** (local muscle strengthening and general aerobic fitness).
3. ***Interventions to achieve weight loss if the person is overweight or obese.***

In adjunct to core treatment (for hand / knee):

1st line: **Consider topical Ibuprofen (see product literature for dosing instructions)** instead of, or in addition to regular Paracetamol (before the use of oral NSAIDs or opioids).[5]

2nd line: **Topical capsaicin 0.025%** should be as an adjunct to core treatments in superficial joints. It may need to be used 4 times a day for 6-8 weeks before pain relief is achieved[6] (then reduce to once a day).

(For full guidance please see NICE CG177, NICE is in the process of reviewing recommendations)

Appendix D: Red flags

****Red Flags[1]:***

- Age < 20 or > 55 years
- Unexplained Weight loss
- Recent history of trauma
- Thoracic pain
- Past medical history of malignant tumour
- Widespread neurological deficit
- Severe or progressive motor loss
- Systemic illness / fever
- IV drug use
- Non- mechanical pain (no relief with bed rest)
- Structural deformity

Appendix E: Signposting

Resources for patients on Pain management

Opioids: the downside – waiting room poster
https://livewellwithpain.co.uk/resources/resources-for-patients/opioids-the-downside-waiting-room-poster/

Sleep Well with Pain leaflet
https://livewellwithpain.co.uk/resources/resources-for-patients/sleep-well-with-pain/

Ten Footsteps: Your Journey to Living Well with Pain
https://livewellwithpain.co.uk/resources/resources-for-patients/ten-footsteps/

Manage your pain leaflet
http://painconcern.org.uk/wp-content/uploads/2016/09/Manage-Your-Pain-English.pdf

Your journey with pain- This short guide gives your patient some ideas for how to live a fuller life, despite the pain.
https://livewellwithpain.co.uk/resources/resources-for-patients/your-journey-with-pain/

Measuring my self-confidence to cope with pain
https://www.sheffieldachesandpains.com/assets/info%20leaflets/persistent/pain%20confidence%20test.pdf

Using the pain toolkit - written self management resources for patients to use
https://livewellwithpain.co.uk/resources/supporting-self-management/using-the-pain-toolkit/

For patients taking opioids for pain:
https://livewellwithpain.co.uk/wp-content/uploads/FPM-OA-taking-opioids-for-pain-Patient-leaflet-2016.pdf

Driving and Pain
https://livewellwithpain.co.uk/wp-content/uploads/Driving-and-Pain-patient-information-Opioids-Aware.pdf

Resources for clinicians:

The great opioid side-effect lottery - this A4 sheet, designed to be used by clinicians in their consultations with patients, is a simple way to raise the question of benefits versus side effects.
https://livewellwithpain.co.uk/resources/medicines-and-your-patient/the-great-opioid-side-effect-lottery/

Appendix F: NSAIDs and adverse effects

NSAIDs & Cardiovascular risk

Naproxen (1g a day or less) or low-dose ibuprofen (1.2g a day or less) have the **most favourable thrombotic** cardiovascular safety profiles of all NSAIDs.

Ibuprofen (2.4 g daily) is associated with an **increased risk** of thrombotic events.[4, 9]

NSAIDs & Gastro-protection

Ibuprofen is associated with the lowest risk of GI s/e and Naproxen has intermediate GI risk (higher doses of ibuprofen increase its risk).

Consider gastro-protection for patients at high risk of GI s/e when starting NSAIDs. High-risk patients includes:

- Over 65 years old.
- A history of peptic ulcer disease or serious GI complications.
- On other medicines that increases the risk of GI s/e, e.g. anticoagulants, aspirin, corticosteroids and antidepressants such as SSRIs, venlafaxine or duloxetine.[18]
- Co-morbidity such as CV disease, diabetes, hypertension, renal impairment (including dehydration) or hepatic impairment use with caution and avoid in severe liver disease.[18]

NSAIDs & Renal impairment

NSAIDs may precipitate renal failure and people at risk of renal impairment (particularly older people) should avoid NSAIDs if possible. Review the appropriateness of NSAID prescribing on a routine basis.[4, 9]

See NICE KTT13 and BNF for more information.

Appendix G – Pain diary

- Pain diary template- https://www.thepaincompanion.com/pain-diary-template.html
- Pain diary app: https://www.catchmypain.com/

Appendix H – Opioid Risk Tool (ORT)

ORT is a brief, screening tool for use with adult patients in primary care settings to a assess risk of opioid abuse in the treatment of pain. ORT can be completed in less than 1 minute and has been validated in both male and female patients but not in non-pain populations.[19] This tool should be administered to patients upon an initial visit prior to beginning opioids for pain management.[19]

Completing the ORT prior to step 3 helps to identify those patients that are likely to be high risk of opioid dependency and abuse if prescribed opioids. It is these patients who particularly need other non-opioid, non-pharmacological strategies for pain management emphasised. It is not an absolute contra-indication to prescribe codeine / co-codamol/ dihydrocodeine but should be done in the context of an opioid trial set up i.e. time limited, dose limited and goal/ function orientated (see details on opioid trials – appendix I).

- **A score less than or equal to 3,** indicates low risk for future opioid abuse.
- **A score of 4 to 7,** indicates moderate risk for opioid abuse.
- **A score greater than or equal to 8**, indicates a high risk of opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, to assess risk of opioid addiction[20]

Appendix I – Opioid trial[3]

- **Before initiation:**

The patient and prescriber should agree on assessable outcomes that indicate that opioids may play a role in the patient's management. These will usually include reduction in pain intensity and ability to achieve specific functional improvement facilitated by the medication. For patients in whom sleep is significantly impaired by pain, improved sleep would be a reasonable outcome.

- **Duration of the opioid trial**

This will depend on the periodicity of the patient's pain. If the patient has constant pain, the opioid trial may be concluded in one or two weeks.
If the patient has intermittent disabling flare ups of pain on a background of more manageable symptoms, the trial should be long enough (4 weeks) to observe the effect of opioids on two or three episodes of increased pain.

- **Choice of opioid formulation and dose**

Where possible, the usefulness of opioids should be explored by prescribing a short (1-2 week supply) of Tramadol immediate-release or immediate release morphine tablets or liquid (**tablets are preferred to liquid formulation** unless there is a specific indication for liquid). The patient may be advised to explore different doses within a specified range e.g. morphine 5-10mg. If reduction in pain is not achieved following a single dose of immediate release morphine 20mg (or MEDD), opioids are unlikely to be beneficial in the long term. A trial of fixed dose regimens using modified release preparations needs to allow for one or two upwards dose adjustments and therefore may take three weeks or more.

- **Assessing whether the opioid trial is a success**

The patient should keep a diary (appendix G) during the opioid trial. This should include a twice-daily report of pain intensity, comment on sleep, note of activity levels and how any of these are changed following a dose of opioid. All doses of opioid should be recorded in the diary with a comment on side effects. If the opioid trial is not successful, the drugs should be tapered and stopped within one week.
If the patient reports no improvement in symptoms following the trial it is very unlikely that long-term opioid therapy will be helpful
If the patient reports reduction in pain but at the cost of side effects that preclude achievement of functional goals, it is reasonable to explore different dosing regimens with active management of side effects to see if a useful balance between benefits and harms can be achieved.
A successful short-term opioid trial does not predict long-term efficacy.

Long term prescribing of opioid.

Choice of Opioid[15]:

Use of immediate release preparations can provide effective symptomatic relief and use of such regimens may be justified when:
• the pain is intermittent and short-lived;
• pain intensity varies significantly: use of regimens including immediate release preparations allows flexibility to reduce dose on days when pain is or is expected to be less severe; or
• background pain is well controlled with modified release preparations but the patient has infrequent, short-lived episodes of increased pain.
Modified release opioids administered at regular intervals may be more appropriate for patients with persistent pain throughout the day and night.

Dosing

Where a dose increase is intended, prescribers must ensure the calculated dose is safe for the patient. e.g. for oral morphine in adult patients, **the dose should not normally be increased by more than 50% of the previous dose**.
Referral is strongly recommended if patients do not obtain useful pain relief with oral morphine **50mg per 24 hours** (or equivalent) or if there are concerns about escalating opiate doses. If opioids are used long term, patients should be regularly reviewed (at least 6 monthly) and doses reduced to the lowest effective dose as soon as possible. As

per BPS and SIGN guidance **it is recommended that doses greater than morphine 90mg twice daily (or equivalent) are only prescribed in consultation with a specialist, i.e before escalating doses further, GPs should seek advice from a pain specialist.** GPs could contact via email/ telephone for specialist advice before referral. GPs should consider other aspects of pain management (physiotherapy, IAPT etc) before referral.
Some patients have **pain that is not responsive to opioids**. If treatment does not improve function or doses escalate due to poor effect, opioids should be reduced & stopped.

Repeat Prescribing[15]

- In general, opioids should not be added to the repeat prescribing system but should be generated as acute prescriptions.
- If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use then consideration may be given for short-term authorisation of repeat prescriptions.
- The prescriber and patient together should review the continuing benefit of opioid therapy and potential harms at regular intervals **(at least twice each year).**

Tramadol:

It has fewer typical opioid side effects, but it **lowers the seizure threshold**, is associated with **psychiatric reactions** and has the potential to produce serotonin syndrome when used concomitantly with tricyclic antidepressants or selective serotonin reuptake inhibitors (SSRIs).
In renal and/or hepatic insufficiency the elimination of tramadol is delayed. In these patients prolongation of the dosage interval should be carefully considered and the use of modified release preparations should be avoided.
Place in therapy: Because of its safety/side effect profile and potential for interactions, tramadol should be reserved for use after a trial with codeine & dihydrocodeine, but may be considered before morphine.
Controlled drug status: As a consequence of increasing reports of misuse and harms, tramadol has been reclassified as a schedule 3 controlled drug. All tramadol prescriptions need to comply with controlled drug prescription writing requirements.
Please see Tramadol SPC for more prescribing information.

Morphine

When modified- release morphine tablets or capsules are used they should be prescribed by brand name due to variations in release profiles.
The elimination of morphine is delayed in patients with renal and/or hepatic insufficiency. In these patients prolongation of the dosage intervals should be carefully considered according to the patient's requirements and the use of modified release preparations should be avoided.
Please see specific manufactures prescribing information on Morphine.

Oxycodone:

Has an efficacy and side effect profile similar to morphine and there are no advantages in using oxycodone first-line. Oxycodone is known to have a higher oral bioavailability than morphine and a 50% dose will give the same analgesic effect. Oxycodone is less likely to accumulate in renal impairment compared to morphine, but it is still contraindicated in severe renal impairment.
Oxycodone should be prescribed by brand name due to the potential for variation in release profile between different prolonged-release branded generics and to minimise the risk of confusion between immediate and prolonged release preparations.
Please see specific manufactures prescribing information on Oxycodone.

Appendix J: Transdermal Patch Preparations

Transdermal patch preparations lack the flexibility required when treating patients with fluctuating pain or uncontrolled pain. Use should be reserved for patients with stable pain who are unable to take or tolerate oral medications (including soluble tablets and liquids).

Reservoir patches (e.g. Tilofyl) **must not be cut** because damage to the rate-limiting membrane can lead to a rapid release of fentanyl resulting in overdose. If the prescriber intends the patch to be cut (NB: unlicensed and not recommended by the MHRA) then the prescription must specify a brand of matrix

Safety of Transdermal Formulations[13]

When transdermal preparations are exposed to heat e.g. if a patient takes a hot bath or has a fever, it may cause increased drug absorption. For more information see the MHRA transdermal fentanyl safety update. (Although this does not specifically relate to buprenorphine the same principals apply).[14]

***Brand prescribing*:** Patches are available as matrix and reservoir formulations; these should not be used interchangeably. To ensure consistency of supply to patients, it is recommended that all fentanyl patches are prescribed by brand.

Transdermal buprenorphine changed at weekly intervals[14]

	5 microgram/hr	10 microgram/hr	20 microgram/hr
Codeine phosphate (mg/day)	120mg	240mg	
Tramadol (mg/day)	100mg	200mg	400mg
Morphine sulphate (mg/day)	12mg	24mg	48mg

NB: Weekly Buprenorphine patches can go up to two patches to make different doses to titrate the dose. i.e 5mcg/hr plus 10mcg/hr to make 15mcg/hr dose.

Transdermal buprenorphine changed every three or four days (twice weekly)[14]

	35 microgram/hr	52 microgram/hr	70 microgram/hr
Morphine sulphate (mg/day)	84mg	126mg	168mg

Fentanyl Patch[14]

Fentanyl patch strength (microgram/hr)	Oral morphine (mg/day)
12	45
25	90
50	180
75	270
100	360
300	1120

Appendix K: Patient agreement form[21]

Insert Practice Header

Diversion Reduction - Patient agreement to take medication as prescribed
Introduction

Any medicine prescribed for anyone is only for that person. If it is given to someone else it may harm them. It is known that some patients are not taking all of their prescribed medicines themselves but are sharing with other people and in some cases, selling it to others.

The risk of harm from this is a concern to us as a practice and so our GPs are asking patients to sign an agreement not to share their medicines with other people.

Responsibilities of the prescriber

- Your doctor is working with you to manage and treat your illnesses and maintain your health.
- Your doctor must be sure that you understand that the medication you are given is for you and only you and that it may harm others if they take it.
- If your doctor feels that you are sharing, swapping or selling your medication **they must** offer closer supervision of your medication to ensure that you don't put your life or the lives of others at risk. This might mean reducing the quantity on your prescription, having more frequent reviews, taking the medication off repeat and asking for a record to show that any lost or stolen medication or prescriptions have been reported to the police.

Responsibilities of the person who is prescribed the medication

- The medication you are prescribed is for you alone to use.
- Do not take more than you have been prescribed, if you feel you need more the please tell your doctor.
- Let your doctor know about any side effects of your medication.
- Attend your appointments with your doctor.
- Keep all of your medication out of the reach and sight of others.
- You agree not to sell, share or swap your medication with others.

You understand that failure to comply with these conditions will result in increased supervision of your medication e.g. smaller, more frequent prescriptions, taking the medication off repeat, asking for a record to show that that any lost or stolen prescriptions or medicines have been reported to the police.

AGREEMENT

I agree to take my medication as prescribed and promise not to swap, share or sell my medication with/to others. I understand that allowing anyone else to take my medication is harmful not just to individuals but also to treatment services. I promise to respect myself by respecting my medicines.

Patient Signature and date	GP Signature and date

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