CONTROLLED SUBSTANCE AGREEMENT

PATIENT NAME: _____ DOB:_____

The purpose of this Agreement is to enter a mutual contract regarding certain medicines (controlled substances) you will be taking or could be taking in the future. Prescription of controlled substances is strictly monitored by state and federal law so strict accountability is necessary.

- **I understand that this Agreement is based on the trust and confidence** necessary in a provider/patient relationship and that my provider will manage controlled substances based on this agreement. _____Pt. Initials

- **I understand that if I break this Agreement**, my provider will stop prescribing these controlled substances. _____Pt. initials

- **I agree to notify my provider of any and all controlled substances or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur within two (2) weeks, or sooner if I have an encounter with my provider, following receipt of prescription. If I fail to alert my provider I understand I may be discharged from the practice. _____Pt. initials

- **I understand that someday my provider may recommend weaning me partially or totally from controlled substances** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other medications or therapies will likely be suggested as part of my new treatment plan. I agree to respect my provider's opinion in such circumstances and comply with the new treatment plan or discuss pursing other treatment venues. _____Pt. Initials

- **I understand that if I am suspected of diverting or distributing my controlled substances, my provider will immediately cease prescribing** these medications. In this case, my provider will be required to comply with local state and/or federal reporting requirements and investigation. _____Pt. initials

- **I agree to consider to follow my provider's recommendation** to seek psychiatric treatment, psychotherapy, psychological treatment or referral to pain management specialist / addictionologist if my provider deems necessary. _____Pt initials

- **If the controlled substances are prescribed to treat pain symptoms, I agree to communicate fully and honestly with my provider** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. _____Pt initials

- **If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.** I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. _____Pt. Initials

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- **I understand the combination of opiates or pain medications with anti-anxiety medications such as Valium or Xanax may increase the likelihood of side effects such as stopping breathing and/or abnormal heart rhythms which may result in injury or death**.
  _____Pt. initials

- **I understand that controlled substances which I may be prescribed have potential risks and side effects, including the risk of addiction**. An over-dosage with a controlled substance may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, reduced sexual function, seizures, coma, and/or aspiration. _____Pt. Initials

- **I will not use any recreational mind-altering or illicit (i.e. marijuana, cocaine, methamphetamine, etc.) substances.** Avoid use of alcohol as I understand alcohol may accentuate or exacerbate side effects associated with legal CS. _____Pt. Initials

- **I will not share, sell or trade my medication with anyone nor will I take other individual's prescribed CS**. _____Pt. Initials

- **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider unless that provider is co-managing care with my current provider**.
  _____Pt. Initials

- **I will inform my provider of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. _____Pt. Initials

- **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed**.
  Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to injury or death. _____Pt. Initials

- **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort including psychological distress, extreme achiness and fatigue, nausea, trembling, etc. _____Pt. Initials

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- **I understand the abruptly stopping chronic higher dose use of benzodiazepines** can cause serious risk to my health and that weaning instructions must be followed explicitly. _____Pt. Initials

- **I will avoid withdrawal symptoms** by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out' of medication is not grounds for insisting on an 'emergency or urgent appointment'. _____Pt. initials

- **I will safeguard my controlled substances from loss or theft**. Lost or stolen medicines will not be replaced. _____Pt. Initials

- **I agree that refills of my prescriptions for controlled substance will be made only at the time of an office visit or during regular office hours**. No refills will be available during evenings or on weekends. _____Pt. Initials

- **I agree that prescriptions for controlled substances will not be refilled earlier than the agreed upon renewal date**. _____Pt. Initials

- **(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this/these medication, I will immediately call my obstetric provider and prescribing prescriber/provider to inform them**. _____Pt. Initials

I agree to use _____Pharmacy,

Located at_____,

Telephone number _____, for filling prescriptions for ***all*** of my controlled substance(s).

- **If I chose to have my medications filled by a new pharmacy not listed above**, I will be required to sign a new Controlled Substance Contract at my next appointment with my updated pharmacy information. _____Pt. Initials

- **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law**. Forged prescriptions and/or forged provider's

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signatures are also against the law. If any of these instances occur, it will result in an immediate termination from this practice. _____Pt. Initials

- **I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances.** If requested, I authorize my provider to provide a copy of this Agreement to my pharmacy or to the requesting government agency. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____Pt. Initials

- I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of controlled substance. Tests may include screens for illegal substances, and my cooperation is required. **Refusal of such testing may subject me to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from this practice.** _____Pt. Initials

- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time and possible termination of care**. _____Pt. Initials

- **I will bring all unused controlled substances to every office visit** _____Pt. Initials

- **I understand that any serious misbehavior** such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice. _____Pt. Initials

- **I agree to follow the guidelines that have been fully explained to me**. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. _____Pt. Initials

This agreement is entered into on this _____day of _____, _____.

Patient/Responsible party signature:

_____ Date: _____ Time: _____

Prescriber/provider signature:

_____ Date: _____ Time: _____

Medication(s) prescribed

_____