Controlled Substance Agreement Terms

You must agree to each of the following statements before a RIM/RWWC provider will prescribe a controlled medication to you:

I am aware controlled medications are prescribed for many reasons, such as to relieve severe pain, relax muscles, suppress a cough, calm anxiety, induce sleep, or aid in drug addiction recovery. **Initial**_____

I recognize I may be subject to a voluntary evaluation by psychologists and/or psychiatrists (possibly at my own expense) before my controlled medication will be prescribed to me. I realize the need to be evaluated by psychologists and/or psychiatrists may be revisited every 3-6 months thereafter while taking this form of medication**. Initial**_____

I understand my medication may produce many unpleasant side effects, including sleepiness, drowsiness, nausea, vomiting, constipation, difficulty urinating, itching, mouth dryness, allergic reaction, decreased libido and sexual function, slowed reflexes and breathing rate, painkiller tolerance, and other undesirable problems. **Initial**_____

I am aware that after taking my medication for a period of time I may develop tolerance and may need increased doses to achieve the same result as before. I am also aware I may become physically dependent on my medication and may experience withdrawal symptoms if I stop taking it abruptly. I understand I am putting myself at risk for psychological dependence or addiction if I abuse my medication and use it to achieve feelings of well-being or mood change apart from its prescribed, medicinal purposes. I recognize tolerance, dependence, and addiction are risks that must be taken into consideration when this medication is prescribed**. Initial**_____

I realize my medication has potential for ***deadly*** interactions with other substances, especially those that suppress the central nervous system such as benzodiazepine tranquilizers, barbiturates, antihistamines, opiates, alcohol, and some herbal supplements. Therefore, I will not use alcohol or illegal drugs while on this medication**. Initial**_____

I am aware if I carry a baby to delivery while taking this medication, my baby will be physically dependent on it. I am also aware this medication is not generally associated with birth defects, but that there is still a possibility that my baby will develop them. Therefore, if I become, or plan to become, pregnant while taking this medication, I will immediately inform my obstetrician. **Initial**_____

I will only take my medication as directed by my **PCP**. I will not take more medication than prescribed unless I have obtained my PCP's authorization first. I understand I will not receive early refills under any circumstance. If my pain control is inadequate, I will schedule an appointment to discuss this with my PCP. **Initial**_____

I realize changes in prescriptions/refills will be made only during scheduled appointments and not via phone or other unacceptable means. **Initial**_____

I promise to not alter my medication in any way – I will take my medication whole and it will not be broken, chewed, crushed, injected, snorted, etc. I understand potential, deadly toxicity could occur due to rapid absorption if I take my medication inappropriately. **Initial**_____

I will not seek or obtain prescriptions for a controlled substance from any source other than my PCP. In other words, I will not seek or obtain controlled medication prescriptions from other clinicians, emergency departments, dentists, and so forth. I understand it is my responsibility to know if I am taking any controlled medications. **Initial**_____

I agree to inform my PCP whenever an outside provider prescribes new medications or diagnoses any new medical conditions. **Initial**_____

I will not give my medication to anyone else; likewise, I will not take anyone else's medication. **Initial**_____

I will keep my medication in a safe place and protect it from theft. I will make sure that it does not get misplaced, wet, or destroyed. I understand my PCP will not give me additional refills if I lose my medication. If my medication is stolen, I understand my PCP will not consider granting an early refill unless I provide him/her with a copy of the police report regarding the theft. **Initial**_____

I agree to allow my PCP to order any urine, blood, or breath testing needed to make sure I am using my medications correctly. I understand I may be tested at any time while I am taking a controlled medication. **Initial**_____

I authorize my PCP to order pill counts of my medication as needed to verify I am taking it properly. I understand my PCP may ask me to bring them my pills in their original container at any time while I am on controlled medication. **Initial**_____

I understand that my physician will issue prescriptions only during office visits. I understand that I will be required to make appointments ahead of time so I do not run out of medications. Initial_____

I recognize that my PCP may choose to issue certain types of prescriptions earlier if he/she or I will be out of town when refills are due. These "early" prescriptions will contain instructions to the pharmacist regarding when they can be refilled. **Initial**_____

I realize my medication slows my reflexes and reaction time. Because of this, I will not be involved in any activity that may be dangerous to myself or someone else while I am on controlled medications; this includes driving a car, working in unprotected heights, and using dangerous equipment. I understand I should not care for another individual who is unable to care for himself/herself while I am under the influence of this medication. **Initial**_____

I am aware that I will be required to follow-up with my PCP for additional refills every 3-6 months. I am aware that my PCP will determine how often my follow-ups will be required and that additional refills will not be sent until I follow-up in-office. **Initial**_____

I will keep follow-up visits as directed by my PCP. If I must cancel an appointment, I will give at least 24 hours' notice and reschedule. **Initial**_____

I will provide at least 72 hours' notice for any and all prescription refills. I understand that if I fail to provide adequate time for my PCP to refill my medication then there may/will be delays in my prescription being refilled. **Initial**_____

I recognize continued refills of controlled substance medications may be contingent upon compliance with other treatments recommended by my PCP. **Initial**_____

I understand if I violate any of the above terms, my doctor may choose to no longer fill my prescription or may require that I obtain help to decrease my use of these medications. In fact, if my PCP believes I am not complying with this contract's terms, or believes I have lied about my compliance with this contract's terms, they may choose to terminate my status as a patient. Initial_____

I acknowledge treatment with controlled substances is contingent on evidence of benefit. I am aware my case will be reviewed periodically to determine whether I am improving or that progress is being made to improve my function and quality of life. If my treatment regimen does not show any evidence of this, I know I may be tapered off controlled medications and a new treatment may be prescribed. Initial_____

I will use caution and common sense while taking this medication. I will ask questions if I do not understand something or if I feel I may be having trouble with the medication. Initial_____

_____ _____

Patient's signature Date

_____ _____

Print Patient's Name Date

_____ _____

Physician's signature Date