Fenton Medical Center

Controlled Substances Therapy Agreement

Name: _____ DOB: _____ Date: _____

Medication: _____ Medical Condition:_____

The purpose of this agreement is to create an understanding regarding controlled substances (a class of medications that are regulated by State and Federal government) that may be used in the treatment of your medical condition.

Our goal is to treat you safely with these medications and also to prevent the abuse of, or addiction to, these medications.

Medications such as opioids (narcotic pain medications), benzodiazepines (tranquilizers), barbiturates (sedatives), hypnotics, and muscle relaxants - that may be useful in managing your condition - can be problematic in several ways. These medications have “street value” and potential for abuse. Although these medications may be prescribed with the goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of an addiction disorder or a relapse in a person with a prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients.

Our goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your condition and improving your function, while at the same time monitoring and managing potential risks. When possible, our goals may include a downward taper and eventually discontinuation of the drug.

Because these medications have the potential for abuse or diversion (i.e. sharing, trading or selling to ANYONE other than whose name is on the prescription), strict accountability is necessary for both medical safety and legal reasons.

1. You must get a prescription for all controlled substances from the prescriber whose name appears below, or - during his/her absence - by the covering prescriber (unless specific authorization is obtained for an exception).

2. You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ .

3. You must inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. You will give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists and/or other medical professionals who provide your healthcare for purposes of maintaining accountability and coordinating care.

5. You may not share, sell, or otherwise permit others to have access to these medications. You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought by individuals who may abuse or divert them and should be closely safeguarded. You will not leave your medications where others might have access to them

6. You should not stop these medications abruptly or without consulting the prescribing physician, as a withdrawal syndrome may develop.

7. You agree that your urine, saliva, or blood may be tested for controlled substances before initiation of therapy, and that random follow up drug screening may be required. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances, or absence of prescribed medications, may prompt referral for assessment for addictive disorder and possible tapering and discontinuation of the controlled substances immediately or in the future. Furthermore, you understand that not all insurances cover the cost of drug screening and that you may be responsible for part, or all of the bill.

8. You must take all medications exactly as prescribed. Medication dose and frequency should only be changed in consultation with the prescriber. Taking too much medication may result in overdose, injury or death. If you run out of your prescription before your next scheduled refill you will not be able to refill early.

9. You must bring original prescription containers with remaining pills to each office visit.

10. You must keep all controlled substances in a secure area. Since these medications may be hazardous or cause death to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people. Keeping controlled substances in a locked cabinet or safe is highly recommended.

11. You must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness, change your mental abilities, delay reaction times, or impair physical coordination, thereby making it unsafe to drive or operate heavy machinery. The effects of these medications may increase or worsen during any dose changes. If you are the slightest bit impaired, you must refrain from these activities or any other activities that put you or others at risk of injury.

12. You acknowledge that taking these medications in combination with alcohol will result in a significant increase in impairment and risk of injury to yourself and others. Additionally, combining certain medications with alcohol may result in respiratory depression which could lead to unexpected death.

13. You agree that medications will not be replaced (refilled early) if they are lost, flushed down the toilet, destroyed, stolen, etc.

14. You agree that early refills will not be given.

15. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this office, or referral for further specialty assessment.

16. You agree that prescription renewals require keeping scheduled follow up appointments. Do not phone for prescriptions after hours or on weekends. Controlled substance refill requests will not be filled by the on-call physician or after hours clinic.

17. If you receive any controlled substances from an Emergency Room encounter, or from another provider (such as a Dentist, Surgeon, or Urgent Care) you must report that incident to this office the next business day.

18. You recognize that any medical treatment is a trial, and that continuing this prescription is contingent on evidence of benefit and improved functionality.

18. You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask and have answered any questions that you may have.

20. FOR WOMEN: You agree that additional risks may be associated with the use of controlled substances during pregnancy. This includes, but is not limited to birth defects, problems with development and behavior, and neonatal abstinence syndrome. If you are intending to become pregnant, or find that you are pregnant, you will notify the prescriber immediately to discuss potential treatment changes.

You understand and agree that failure to adhere to these policies will be considered a breach of this agreement and may result in discontinuation of medication prescribing by this clinic and possible dismissal from this clinic.

You affirm that you have full right and power to sign and be bound by this agreement. You further affirm that you have been given the opportunity to ask any questions you may have and that you have read, understand, and accept all of its terms.

Patient Signature: _____ Date: _____

Patient Name (Print):_____

Prescriber: _____ Date: _____