(Name of Office/Practice)

Agreement for Safe & Effective Controlled Substance Prescriptions

This Agreement is between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date of Birth) and the (name of office/practice). My doctor has prescribed one or more medicines to treat my \_\_\_\_\_\_\_\_\_\_\_\_\_ (name of condition). These medicines are high risk and can be misused, abused, or lead to addiction. In order to comply with federal and state regulation and for my safety, I agree to the following statements. I know that if I do not follow the statements below, my controlled substance prescriptions and/or treatment at (name of office/practice) may be ended immediately.

1. \_\_\_\_ I know that control substances are one part of my treatment plan to help my condition and make my quality of life better. I know that controlled substances will not cure my condition. I understand that if my function does not improve while taking these medications, the medicine may be discontinued or the dose may be lowered.
2. \_\_\_\_ I understand that in order to best treat my condition, it will require me to commit to a healthy lifestyle; including eating a healthy diet, staying as physically active as possible and managing my stress. I agree to work with my provider to achieve a healthy lifestyle.
3. \_\_\_\_I know that my treatment may change as my provider evaluates my progress or more medical information is available. If my doctor feels I need to see a specialist, I agree to get a consultation.
4. \_\_\_\_I know that if I stop the medication suddenly, I may have severe withdrawal symptoms.
5. \_\_\_\_I am responsible for my controlled substance medications. I understand that sharing, selling, or trading my medication is illegal and is a felony. If the paper prescription and/or medication is lost, misplaced, or stolen, or if I use it up too soon, I know that the medication will **not**be replaced I agree to bring in my medications for pill counts at the request of my provider.
6. \_\_\_\_I will not ask for or take controlled substance medications from another doctor or person. If I am given these medications by another physician or in a time of emergency, I will call the St. Vincent Primary Care Center the next business day to let my provider know.
7. \_\_\_\_Refills of controlled substances will only be given if I keep my scheduled appointment(s). I will call at least 3 business days ahead if I need a refill on the controlled substance medication(s) and know that refills will only be granted during regular business hours, Monday through Friday.
8. \_\_\_\_I know that any controlled substance may interfere with or impair my ability to drive, perform intricate tasks and make important decisions. I understand that it is my responsibility to refrain from any activities that will endanger me or others while taking a controlled substance.
9. \_\_\_\_I will not use illegal drugs, including marijuana,. I agree to give random urine for drug testing to make sure I am safely using my medications. If other drugs are found in my urine that are not prescribed or illegal, I understand that my provider will be unable to prescribe further controlled substances and that I will be referred for help with chemical dependency.
10. \_\_\_\_I agree to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy, located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, for **ALL** my controlled substances. If I change my pharmacy for any reason, I agree to tell my provider.
11. \_\_\_\_For Females of child bearing potential ….I understand that taking controlled substances while pregnant is dangerous. Taking controlled substances during pregnancy can cause harm to a fetus and can lead to severe neonatal withdrawal after birth.

I have read and I understand this agreement.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_

Physician’s Signature Date\_\_\_\_\_\_\_\_\_