Affinia Health Network

Controlled Medication Agreement

Patient Name: _____ **Patient Date of Birth:** _____

Medication(s):_____

Diagnosis:_____

Primary Prescribing Doctor:_____

Patient should INITIAL each statement

About this medication:

___ This medication may help my pain, but it may not.
___ Opioid pain medications often have side effects, which may include:
Itching or rash
Severe Constipation (most people need help with this)
Trouble with urination
___ Opioids and/or Benzodiazepines side effects also include:
Depression getting worse
Problems thinking clearly
Trouble breathing
Death
___ Combining drugs or alcohol (especially opioid plus sleep or anti-anxiety medications) can cause:
Overdose
Trouble breathing
Trouble thinking, poor judgement resulting in harm to self or others
Death
___ I could become addicted to this medication.
___ If I must stop this medication, I need to stop it slowly to avoid feeling sick from withdrawal symptoms. In severe cases, benzodiazepine withdrawal can cause seizures or death. If I decide to stop my medication, I will contact my doctor.
___ My doctor can only prescribe this medicine if I do not use illegal drugs, including any form of marijuana.
___ If I do not use this medication exactly as prescribed, I risk hurting myself and others.
I will not increase my medicine dose without being told to do so by my doctor. The medicine will not be refilled early.
___ I am in charge of my medicine. I know my medicine will not be replaced if it is lost or stolen. I will not share or give this medicine to other people. Narcotic pain medications must all be obtained from the same pharmacy each time (any exception must be approved by my doctor).

What can I do to help?

___ Bring my pill bottles, with any pills that are left, to each clinic visit.
___ When asked, I will give a urine, saliva and/or blood sample to help monitor my treatment.
I UNDERSTAND THAT CLINIC POLICY REQUIRES ROUTINE RANDOM TESTING.
___ Keep appointments and tests set up by my doctor. These may include physical therapy, X-rays, labs, mental health, etc. If I miss my appointments, it may not be safe for me to stay on this medicine. If I miss appointments, my doctor may want an office visit before refilling medications.

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___ My doctor will check my prescription fill history by State Pharmacy Registries and may call my pharmacy.
___ If my doctor decides that this medication may harm me more than it helps me, my medication will be stopped in a safe way.

How can I get my prescription?

___I can get my prescription from my primary prescribing doctor's office during office hours ONLY. Policy prevents on-call doctors from giving refills.
___I will NOT get controlled medications from OTHER providers (including dentists, specialists, emergency room or urgent care).
___Controlled substance medications are monitored. I will make arrangements with my primary care providers ahead of time for refills; give 48-72 hour advance notice.
___I will keep regularly scheduled visits with my doctor to continue to get refills; the frequency will be determined by myself and my doctor.
___Only I (or someone I choose) can pick up my prescriptions or my medications; that person may need to show an ID.

What are the reasons for ending this agreement?

___If I take more medication than is prescribed.
___If I fail to give requested urine, saliva or blood for testing.
___If those tests fail to show the proper amounts of my prescribed medication, if non-prescribed medications (from friends, other prescribers, ED, street purchases) are present, or if illegal drugs are present.
___If I am disruptive or threatening toward our office staff or pharmacy staff.
___I understand that the non-medical use of controlled substances (lying to get medications, giving or selling these medicines to others) is a crime and will be reported to law enforcement.

___I understand that I must work with my medical team in taking care of my health and managing my pain. This is a partnership!

I have read and understand this agreement, and have been able to have all questions answered. I agree to the terms of this agreement.

_____

Patient Signature **Date**

_____

Pt. Representative (if applicable) / Relationship to Patient **Date**

_____

Witness Signature **Date**

_____

Physician Signature **Date**