MERCY HEALTH | MERCY HEALTH PHYSICIAN PARTNERS

Controlled Substance Agreement

Name: _____Date: _____

Birth Date: _____Office: _____Provider: _____

We agree that at this time this prescribed medication is needed to help me do my daily activities. If my baseline activity level or general functioning gets worse, the prescribed medication may be changed or stopped. Please read and initial the boxes to indicate that you (and/or your parent/legal guardian) have reviewed the information, then sign the Controlled Substance Agreement.

Opioid (for pain)
Benzodiazepine (for anxiety)
Sedative/Hypnotic (for sleep)
Other _____

Patient Initials: _____ ☐ Not applicable

1. ***I understand*** that overdosing on my prescribed medication may cause me to stop breathing and may cause brain, liver, or kidney damage, or death.
2. ***I understand*** that side effects of using this prescribed medication may include: constipation (possible side effect of an opioid medication), sexual performance issues, nausea and vomiting, allergic reactions, drowsiness, dependence or addiction, and other side effects.
3. ***I understand*** that if I am pregnant, using this prescribed medication may have risk for my unborn child, including neonatal abstinence syndrome (withdrawal for the child).
4. ***I understand*** that the prescribed medication I take may make me tired, may impair my ability to drive or use heavy machinery, or may impact my daily activities.
5. ***I understand*** that suddenly stopping some prescribed medications may cause withdrawal symptoms such as vomiting, severe shaking, sweating, and nervousness. Withdrawal from some medications may potentially be life-threatening.

Stimulant

Patient Initials: _____ ☐ Not applicable

1. ***I understand*** that side effects of using this prescribed medication may include: nervousness, insomnia, tachycardia (fast heart rate), hypertension, dizziness/lightheadedness, nausea, sexual performance issues, seizures, allergic reactions, dependence or addiction, sudden death, and other side effects.
2. ***I understand*** that if I am pregnant, using this prescribed medication may have risk for my unborn child.
3. ***I understand*** that suddenly stopping some prescribed medications may cause withdrawal symptoms such as vomiting, severe shaking, sweating, and nervousness. Withdrawal from some medications may potentially be life-threatening.

Office Processes

Patient Initials: _____

1. ***I agree*** to go to psychological counseling and other treatments as recommended by my provider.
2. ***I agree*** to review the warning labels and patient information for my medications.
3. ***I will*** schedule and come to appointments when asked to by my provider.
4. ***I will*** give urine and blood samples to check for prescribed and non-prescribed medications in my body as requested by my provider.
5. ***I will not*** get my prescribed medications from any other provider or clinic, except my office during regular office hours.
6. ***I will*** notify the office on the next weekday if I am given prescribed medication in an emergency situation.
7. ***I will not*** take more of my prescribed medication than what my provider has instructed.
8. ***I understand*** that lost or stolen prescribed medications will not be replaced.
9. ***I will not*** call for early refills.
10. ***I will*** bring my unused prescribed medications and the empty bottles when asked.
11. ***I will not*** be disruptive or threatening toward office staff or pharmacy staff.
12. ***I will not*** share, sell, or trade prescribed medications with anyone.
13. ***I understand*** that combining "street drugs," alcohol, or benzodiazepines (such as Ativan®, Xanax®, or Klonopin®) with my prescribed medications may be **deadly**. ***I will not*** use "street drugs," or take friends' prescribed medications.

Legal Processes

Patient Initials: _____

1. ***I understand*** that my provider will monitor my prescribed medication use through the Michigan Automated Prescription System (MAPS), which allows providers to see what medications have been prescribed for me. ***I understand*** that a copy of the MAPS report cannot be given to me by my provider due to state laws.
2. ***I understand*** my provider is under no obligation to prescribe medications to me and may stop at any time.
3. ***I understand*** that this Controlled Substance Agreement will become part of my electronic medical record and will be shared in the same protected manner as my other medical records.
4. ***I understand*** that changing or forging prescriptions is a federal crime. If I change or forge a prescription, the police will be notified.
5. ***I understand*** that selling (diverting) prescribed medications to others is a felony.
6. ***I understand*** that I should secure prescribed medications to prevent access for others in my home, and I should properly dispose of unused prescribed medications through accepted methods.

I have read this agreement, and I understand everything in it. By signing my name, **I agree to follow it.** If I do not follow this agreement, the office may stop prescribing controlled substances. I understand that I must work with my medical team in a partnership to manage my health.

Patient Signature:

_____ Date: _____

Parent/Legal Guardian Signature (if Patient is a Minor):

_____ Date: _____

Provider Signature:

_____ Date: _____