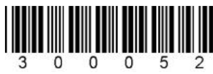
SHARED ELECTRONIC HEALTH RECORD



CONTROLLED SUBSTANCE AGREEMENT

Patient Name: ____________________

MRN: _______________ DOB: ________

Treatment Location: _______________

Controlled Medication Prescribed: ❑ Narcotics/Opioids ❑ Benzodiazepines/Sedatives ❑ Stimulants/Amphetamines

Medication(s): ____

This document is an agreement between the health care provider prescribing a legally controlled medication and you, the person being prescribed the medication. It is intended to help both parties work together to ensure the safe, effective and best possible use of the medication. While the medication may be helpful for some symptoms and illnesses, it also poses a risk of death, significant side effects, medication tolerance or dependence, abuse, addiction, and misuse. The medication also may cause severe reactions if used by individuals other than the patient. You should sign this agreement only after reading it and asking any questions that you may have regarding the terms.

I will use the above listed medication only as prescribed by this provider. I will ask no other medical provider to prescribe this medication. If another medical provider gives me any other medications checked above, I agree to let the provider listed below know immediately. I will inform all health providers that I am taking this medication when my medical history is requested.

1. **I will fill my prescriptions for the above medication only at one pharmacy and will promptly notify the provider if I change pharmacies.** I hereby authorize the continuing release of information relating to my prescription medication to all involved providers, prescribing practitioners and pharmacies. I understand that the State of Maine's Office of Substance Abuse also monitors all controlled substance prescriptions and may provide a report to my provider about all of my controlled substance prescription refills.
2. **I will not take the medication in excess of the prescribed dose.** If I think that I need a change in the dose of my medication, I will discuss this with my provider before making a change in the dose. If I use up my medication before I am due for a refill, then I understand that I will have to do without this medication until my next refill is due.
3. **It is my responsibility to safeguard my medication.** Lost or stolen prescriptions will not be replaced. I will be sure that they are kept away from children and other individuals.
4. **It is my responsibility to keep my refills up to date and to keep my scheduled appointments**. Refills generally will be provided during provider appointments. If I need a refill between appointments, I will call at least 48 hours before my medication supply is used up. Refill requests made on Friday may not be filled until the following Monday. Refills will **NOT** be issued after hours, on weekends, or on holidays. It will be my responsibility to re-schedule any regular appointments that I cancel or miss. Urgent visits will not be scheduled unless medically necessary for treatment of my underlying condition.
5. **I will not use illegal substances or non-prescribed controlled substances while taking the medication.** I will discuss with my provider the risk of alcohol consumption while taking this medication.
6. **I agree to provide blood and/or urine sample for testing upon request at any time.**
7. **I will not sell, trade, or otherwise permit others to have access to this medication.**
8. **I agree to bring in my medication in its original container for a pill count at any time it is requested by my provider**. (For patients under the age of eighteen, parents or legal guardians understand that they have ultimate responsibility for safeguarding the medication supply.)
9. **I understand that the use of this medication poses certain risks to my health as outlined by my medical provider at the time of the original prescription.**
10. **I understand that there may be alternative treatments for my condition that do not include the use of this medication.** I will accept referrals to other providers, including pain, mental health, and substance abuse specialists when recommended by my primary medical provider.
11. **I will fully participate in all treatment modalities recommended by my provider.** I understand that other treatments, in addition to this medication, as outlined in my treatment plan, are very important for my progress. If I do not actively participate in these other treatments, then I realize that my medication may not continue to be prescribed.
12. **I agree to participate in the tapering of my medication when my provider believes that a lower dose would be safer and more appropriate for my medical condition.**
13. **I will be respectful and courteous towards all staff at all times.** Any verbal abuse, either in person or via the telephone or physical threats will result in my immediate dismissal from the practice and referral to another practitioner.
14. <u>If I violate any of the above conditions, I understand that my medical provider may discontinue prescribing the medication. I further understand that my provider will continue the medication only if it leads to a clear benefit to my medical condition.</u>

X ____________________	AM|PM ____________	X ____________________
Signature of Patient or Authorized Representative	Date| Time	Witness Signature
____________________	____________________	____________________
Signature of Physician or Designee	Printed Name	Date/24H Time