



AGREEMENT FOR LONG TERM USE OF CONTROLLED MEDICATIONS

The majority of patients who are prescribed controlled medications take them safely and appropriately. However, all controlled medications have some potential for misuse, abuse, and addiction.

The use of _____
(name of medication) may cause addiction and is only one part of the treatment for:

(name of condition).

The goals of this medicine are:

- to improve my ability to work and function at home
- to help my condition as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I, or anyone in my family, has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- ✓ I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- ✓ I will not increase my medicine until I speak with my doctor or nurse.
- ✓ My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed. I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)

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- ✓ I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- ✓ I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours, no refills on nights, holidays, or weekends.

- I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made.
- I must keep track of my medications.
- No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is _____

Address: _____

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

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Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

Patient's signature

____ / ____ / ____
Date

Physician's signature

____ / ____ / ____
Date

This document has been discussed with and signed by the physician and patient.

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