S&H Youth and Adult Services, Inc.
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SHYAS
Your Place of Security & Hope

Controlled Substance Agreement

The purpose of this contract is to establish an agreement between the provider and patient on conditions for prescribing and use of controlled substances in the event use of these agents is deemed medically appropriate. This agreement is essential in maintaining the trust and confidence necessary in the clinician/patient relationship. Should controlled medication be a part of your treatment, the frequency and type of medication prescribed is, and must be, under the discretion of your prescribing clinician. Your treatment may require the use of controlled substances which may include, but not limited to, hypnosedatives or stimulants. The use of controlled substances carries several risks, such as physical dependency, when used on an extended daily basis.

Side effects from hypnosedatives and stimulants include, but are not limited to, drowsiness, fatigue, impaired coordination, irritability, memory impairment, lightheadedness, dizziness, sexual difficulties, depression, confusion, weakness, constipation, changes in appetite or weight, palpitations, increased heart rate and /or blood pressure, psychotic episodes, restlessness, overstimulation, insomnia, euphoria, tremor, exacerbation of tics, dry mouth or possible worsening of clinical psychiatric condition. Taking more controlled substances than as prescribed and/or combining controlled medications with other medications, illicit substances or alcohol could result in life-threatening conditions including but not limited to respiratory failure, cardiac failure, coma, organ damage or even death. Another serious problem associated with prescribing controlled medications is the diversion of controlled substances for resale. Diversion is defined as use of prescription medications for nonmedical recreational or illicit purposes.

Withdrawal symptoms from hypnosedatives may include, but are not limited to: insomnia, muscle cramping, vomiting, sweating, tremors, convulsions or death.

Withdrawal symptoms from stimulants may include, but are not limited to: depression, intense fatigue and sleepiness.

Tolerance can occur with these medications and is defined as requiring increasing doses of the medication to obtain the same effect. Tolerance is differentiated from addiction. Addiction involves abnormal social behavior to obtain controlled substances such as stealing, lying or abusing the medications that have been prescribed. Addiction is not typical in patients who do not have a prior history of addiction to controlled substances, alcohol or illicit substances.

The rules of this agreement may seem extremely strict and demanding. These rules are intended to protect you and others from the improper use of controlled substances. Your clinician believes that these rules are fair and necessary. Your understanding of these liabilities is important and appreciated by all your health care professionals. This agreement must be signed and returned upon your initial visit or signed at the request of your clinician or staff at Cornerstone Psychiatric Services. You may request a copy of this agreement at any time.

By signing this form, I have read, understand and agree to the following:

- All controlled substances will be taken only as prescribed.
- That I have been informed of the risks and side effects of controlled substances.
- To be seen and evaluated at least every 3 months to assess the efficacy and appropriateness of treatment.
- All controlled substances will only be prescribed for 30 day supply.
- All controlled substances will only be prescribed if there is active participation in outpatient therapy or substance use treatment program. With weekly visits for the first 30 days, biweekly visits for the subsequent 30 days, & once every 30 days after that.
- To contact your provider to seek approval should I feel my medications should be altered in any way other than prescribed.
- Not to increase dosage of my controlled medication unless authorized by your prescribing provider or on-call provider.
- To exercise caution when performing activities, such as driving or operating heavy machinery.
- Not to use any illegal substances, including marijuana, cocaine, etc.

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- Not to use the medication with any alcoholic beverages.
- Not to share, sell or trade my medication for any reason, including money, goods or services.
- Not to attempt to obtain controlled substances from any other health care provider without disclosing the current medications prescribed.
- To bring any remaining controlled substances in their proper containers at the request of your provider or staff. These medications may be counted by any of the SHYAS staff at any time.
- It is my responsibility to protect and secure any controlled medications prescribed to me, which may not be replaced if lost or stolen.
- To obtain all my controlled medications from only one pharmacy.
- To notify SHYAS office immediately should I change pharmacies and to furnish my new pharmacy with the address and telephone number of my old pharmacy.
- Your clinician or designated staff at SHYAS will access and obtain Controlled Substance medication(s) history through the use of the State of North Carolina controlled substance monitoring database.
- To authorize SHYAS and my pharmacy to fully cooperate with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my controlled substance(s).
- To authorize SHYAS to provide a copy of this agreement to my pharmacy.
- To submit a blood or urine test, at random, and/or when requested by any SHYAS staff to determine my compliance with this contract.
- Failure to comply with this contract may result in the withdrawal of all controlled substances, which may result in referral to a detoxification and substance treatment program, as well as termination of the clinician/patient relationship.
- I agree to release the staff at S&H Youth and Adult Services, Inc. (SHYAS), from all responsibilities and obligations of the clinician/patient relationship should I breech this contract and I understand I will be terminated as a patient of SHYAS.

I have read, fully understand and agree to comply with this contract. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that this agreement is good for the duration of services with S&H Youth and Adult Services, Inc.

Patient/Guardian Signature	Date
Patient Name	Patient Date of Birth

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