

Patient Agreement Form

Patient Name: _____ Date of Birth: _____

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for: (print name of condition-e.g., pain, anxiety, ADHD, etc.).

The goals of this medicine are:

- To improve my ability to work and function at home.
- To help my _____ (print name of condition-e.g., pain, anxiety, etc.) as much as possible without causing dangerous effects.

I have been told that:

- 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.
- I may get addicted to this medicine.
- If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
- 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).
- 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

I must keep track of my medications. No early or emergency refills may be made. I will call 2-3 days prior to alert of my need for a refill.

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 _____

Prescriptions from other doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from E.R. 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.

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