Controlled Substance Agreement

Guidelines of Controlled Substance Agreement

1. Martin Medical Center will only manage pain, ADD, ADHD, Anxiety, and Insomnia, of patients whom we are the primary care provider for.
2. To be place on pain medication agreement patient must have documented evidence of medical condition and treatment modalities tried/in process of ie. ex. Physical therapy, tens unit, lab resulted, ADHD assessment, Connor scales , Vanderbilt's ADHD assessment .
3. Labs must be drawn at least once a year
4. Monthly UDS- Urine Drug Screen
5. Patient with chronic bone pain pt must have current x-ray, NCS, MRI, CT in past 2 years testing period
6. If patient scores 8 or above on 'Opioid Risk Assessment Tool' they are an automatic chronic pain management referral
7. Patient Must be compliant with all medical advice and instructions-or breech agreement
8. Patient must fill all meds prescribed by provider

Controlled substance agreement

Dr. ______________________________ and staff have explained the risks and benefits of being on a controlled substance.

I, ______________________________, understand that I must comply with the following rules or I will not be prescribed a controlled substance. I will fill the prescription at one and only one pharmacy.

Pharmacy name ________________________ Phone ____________________________

I will take the medication, ______________________________, as it was prescribed and only in that way.

I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner.

I will report any worrisome side effect soon after it begins.

I will follow through on appointments that may help me with health care needs. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery,

neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the controlled substance.

If prescribed, I will use alternative medication or adjunctive medication in conjunction with controlled substance.

I will accept controlled substances from my Primary care provider's at Martin Medical Center

I will not share, exchange or sell my controlled substances as the law prohibits those actions. I understand that my provider will report serious concerns of medication misuse to any and all authorities for investigation.

I will not use illegal/street drugs (this includes marijuana). I will not use narcotic medications unless provided to me from my provider.

I agree to provide samples for monthly urine drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

I will not get early refills unless something has dramatically changed and then only if my provider agrees.

I recognize that controlled substances by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medications safe. If controlled substances are lost, damaged or stolen, the medication will not be refilled till next scheduled visit. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications will not be refilled.

If a new condition develops that cause's acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the controlled substances altogether.

I understand that my provider may decide to stop the controlled substance if after increasing it adequately, my condition and function have not responded positively.

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care.

PATIENT SIGNATURE ____________________ DATE ________

WITNESS SIGNATURE ____________________ DATE ________

PROVIDER SIGNATURE ____________________ DATE ________