Patient Controlled Substance Agreement Form

Patient Name_____ **DOB**_____

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, 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 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.
- I will keep all appointments set up by my doctor.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- 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—Monday through Friday, 8:00AM-5:00 PM. 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.
My pharmacy is: (name) _____ (number) _____.

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 Grayson & Associates 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 psychiatric care for you even if you are no longer getting controlled medicines from me.

_____ _____
Patient's signature Date

_____
Prescriber's signature

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