Name: _____
DOB: _____
Working Phone: _____

COMMUNITY HEALTH CENTERS
OF THE RUTLAND REGION

Controlled Substance Management Agreement

List of controlled substances

_____

_____

_____

_____

_____

The purpose of this agreement is to prevent misunderstandings about controlled medicine that you will be taking for pain management or other medical conditions. This is to help both you and your healthcare Provider comply with the law regarding controlled substances.

I understand that this agreement is essential to the ***trust and confidence necessary in a Healthcare Provider /Patient relationship.*** I understand that my healthcare Provider is under no obligation to prescribe these medications for me. He or she reserves the right to discontinue these medications at any time. I agree to cooperate with witnessed random drug testing, and/or a pill count(s) at any time. I will be required to comply with a random drug screen and/or pill count within 24 hours of notification. It will be my responsibility to find transportation to have my drug screen and/or pill count performed. In addition, I must have a current phone number in which I can be contacted at all times.

I understand that these medications have potential risks and side effects, the most significant being:

1. **Physical dependence** which means that abrupt discontinuation of the medication could lead to withdrawal symptoms such as abdominal cramping, diarrhea, anxiety, seizures, and death.
2. **Psychological dependence** or addiction which means that my behavior becomes focused on obtaining additional medication.

3. **Overdose** of the medication leading to respiratory arrest and death.
4. **Mental changes** such as confusion, sedation, and changes in my thinking ability. I understand that the medication may interfere with my ability to operate motor vehicles, large equipment, machinery, appliances, etc.
5. **Other side effects** may include, but are not limited to the following: nausea, constipation, unsteadiness, decreased appetite, problems urinating, sexual difficulties and depression.

I will take the medication only as prescribed. I will not take any sedatives or other controlled medications without prior approval from my healthcare Provider. I will not use any illegal controlled substances. I will not seek or accept any controlled medications other than those prescribed by my healthcare Provider. These include prescriptions from other healthcare Providers, and any controlled medications borrowed or accepted from anyone else. If for any reason I am given a prescription for any controlled substance from an outside Provider (e.g. an ER Provider or Dentist), I will notify them that I am currently under a narcotic contract and will let my CHCRR Provider know as well.

I understand that my controlled medication will only be prescribed by _____ according to our agreed upon schedule. I agree that refills of my prescriptions for controlled medications will be made only at the time of an office visit or during regular office hours. **No refills will be available during the evenings, on weekends, or on holidays. There will be no exceptions.** Picture identification will be required when picking up prescriptions.

I understand that two (2) appointment cancellations or two (2) no-show appointments related to controlled medication may constitute grounds for termination of this agreement.

I understand that lost, spilled, or stolen controlled medications will not be refilled under any circumstances. It is my responsibility to protect and secure my controlled medications. This includes keeping controlled medication out of the reach of children and/or pets.

I agree to be seen at least every 3 months for my controlled medication use (or per my Provider's discretion) and will communicate fully with my healthcare Provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

I understand that my Provider may require evaluation of my treatment by a pain management specialist, physical therapist or psychologist. I am also aware that I may be required to participate in ongoing counseling. I understand that these may be extremely important in my care, and I agree to keep appointments when my Provider refers me. By not doing so, I agree that my contract may be terminated.

I understand that I am prohibited from carrying weapons of any sort onto the doctor's office premises.

In addition to the above agreements, I accept the rights of my healthcare Provider to terminate this agreement for any of the following reasons:

1. I seek or obtain any controlled medications from any source other than my Provider.
2. I give, sell or in any way distribute prescribed controlled medications to any other person.
3. If any drug screen does not indicate an appropriate level of prescribed medication.
4. When completing my pill count, pills other than those prescribed are identified.
5. I fail to bring in all my prescribed controlled substances or my pill count is inconsistent.
6. I in any way attempt to forge or alter a prescription at which time I will be reported to the police.
7. My medical condition declines to such an extent, which in the professional judgment of my healthcare Provider, continued therapy with this medication presents a danger to my well being or safety.
8. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my healthcare Provider determines that I am no longer a good candidate to continue the controlled medication.
9. I demonstrate any aggressive behavior including, but not limited to, verbal or physical abuse against anyone at the healthcare clinic.
10. I am found to be in possession of illegal substances or weapons of any kind.

Narcotics and the Law

State and Federal laws and regulations place specific restrictions on prescription and use of controlled medication. These laws apply to both patients and providers. This agreement's main purpose is to protect the patients' health. It also requires that patients and providers do not violate the law. Specific legal issues to be aware of include:

- **Vehicles-** it is illegal to drive any vehicle, including cars, trucks, SUVs, and ATVs if the driver is impaired by controlled medication.
- **Fraud-** it is illegal to use fraud or deception to obtain controlled medication. This includes forgery, pretending to be somebody else, or asking more than one provider for medical advice for the purpose of getting additional controlled medication.

In the case of termination, my healthcare Provider will taper me off the controlled medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended. In situations where there is no sign of my controlled medication in my drug screen, my controlled medication can be terminated immediately.

I agree that I will fill my controlled medication prescriptions from one pharmacy only. Under no circumstances will I obtain controlled medications from more than one pharmacy at a time.

I agree to use _____Pharmacy, located in _____ _____. (City)
(State)

I authorize my healthcare Provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medication. I authorize my Provider to provide a copy of this agreement to my pharmacy and any other health care Provider that may be involved in my medical/dental care. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

Under this agreement, I understand that if my actions cause legal authorities to ask questions about my treatment with controlled medication, all confidentiality is waived. These authorities may be given full access to my prescription records and medical records related to my treatment with controlled medication. I also understand that any information about illegal drug-related activity on my part may be reported to appropriate law enforcement agencies.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of controlled medication prescriptions and possibly the termination of services from my healthcare Provider and his or her practice.

_____ ____/____/____
(Patient signature) (Date)

_____ ____/____/____
(Healthcare Provider signature) (Date)

Revised 1/23/13 C Courcelle, S Czachor, J Gearwar, J Grimes