Controlled Substance Agreement

Controlled substances can be used for the control of pain or certain other medical conditions. Due to the potential for these substances to be mis-used and to cause harm, they are carefully regulated. To safely use these medications requires an understanding of potential problems, a clear agreement between patient and provider, and close follow-up with the provider.

Particular issues that should be discussed and understood by patients include:
(a) safe use of the medicine,
(b) habituation or tolerance to medication effects,
(c) common side effects and interactions with other medicines,
(d) possible problems with safe operation of motor vehicles and machines
(e) whether and how much alcohol can be used safely while taking the medicine,
(f) how to safely discontinue.

In order to be able to receive prescriptions for controlled substances from the providers at the Hilltown Community Health Centers, I agree to abide by the following conditions:

1) To keep all regularly scheduled appointments with my provider, and to obtain all prescriptions for controlled substances at the time of regular appointments.

2) To safeguard prescriptions and medications to avoid losing them, and not to give or sell any of my medication to others to use. Lost or stolen medicine will not be replaced.

3) To not buy or take controlled substances that are not prescribed.

4) To take medications only as prescribed.

5) To notify my primary care provider of all medication prescribed to me by other providers, and to notify all other providers of all medication I am taking when seeing them.

6) To keep all appointments with specialists, physical therapists, psychotherapists, and other providers as agreed to with my primary care provider.

7) To obtain all controlled-substance prescriptions from only one pharmacy.

8) To limit or avoid the use of alcohol as agreed to in discussion with my provider.

9) To not use illegal or "recreational" drugs such as cocaine, ecstasy, speed, etc.

10) To exercise caution operating machines or motor vehicles, as these medicines can impair my ability to do so safely.

11) To have urine drug screening at the request of my provider.

12) To come to the Health center with my medications for a "pill check" at the request of my provider.

_________________________  ________________________
Patient name/signature      Date

Witness/Provider signature   Date

_________________________  ________________________
Initial                  Date  10/09

I have received a copy of this contract.