ANNAPOLIS FAMILY MEDICINE

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www.AnnapolisFamilyMedicine.org

Controlled Substance Patient Agreement

Patient Name: _____ DOB: _____

Controlled substances (i.e. opiates, benzodiazepines, hypnotics, stimulants) are very useful, but have a high potential for misuse and are therefore closely controlled by local, state, and federal government. They are intended to improve function and or ability to work, not simply to feel good.

Because my provider is prescribing such medication for me to help manage my pain/anxiety/ADD/insomnia, I agree to the following conditions:

- If the prescription of medication is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced. The CRISP database will be checked at every refill request.
- I will not request or accept controlled substances from other providers or individuals while I am receiving such medications from my AFM provider. Besides being illegal to do so, it may endanger my health. The only exception is when it is prescribed while I am at a hospital.
- I am responsible for taking the medication at the dose and frequency prescribed, and for keeping track of the amount remaining.

Refills of controlled substances:

- Will be made only during regular office hours, during a scheduled office visit. Quarterly refills will be considered on a case-by-case basis, otherwise it may be monthly.
- Providers within AFM who are not my designated primary care provider may refill my controlled substance, but may only dispense a one-month supply.
- Refills will not be made at night, on weekends, or on holidays.
- Will not be made if the prescription is lost, misplaced or used up early.
- I will call at least 48 hours ahead if I need assistance with a controlled substance and will be through only one pharmacy that is to be recorded in the medical record. Use of more than one pharmacy, unless prior approved by my provider, will constitute a violation of the contract.

  NAME/LOCATION OF PHARMACY : _____

- I agree to comply with urine or blood testing documenting the proper use of my medication as well as confirming compliance. This will be done annually, and possibly more frequently, as determined by my provider.
- I understand that driving a motor vehicle is not allowed while taking controlled substances and that it is my responsibility to comply with the laws of the state while taking the medication prescribed.
- I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain.
- I understand that the long-term advantages of chronic opiate, benzodiazepine, and hypnotic use have yet to be scientifically determined and that treatment may change based on these outcomes.
- I understand, accept, and agree that there may be unknown risks associated with long term use of controlled substances and that my provider will advise me as knowledge and training advances and will make appropriate treatment changes.
- It may be deemed necessary by my provider to see a specialist at any time while I am receiving controlled substances. I understand if I do not attend this appointment that my medications may not be continued beyond a tapering dose to completion. I understand that if this specialist feels I am at risk for psychological dependence that my medications may no longer be refilled.
- I understand that if I violate any of the above conditions, my controlled substance prescription may be ended immediately.
- If the violation involves obtaining controlled substances from another individual, as described above, or the concomitant use of non-prescription (illegal) drugs, I may also be reported to my provider, medical facilities, and other appropriate authorities.

I have read this contract and the same has been explained to me by my provider or designated office staff. In addition, I fully understand the consequences of violating this contract.

Patient Name: _____ DOB: _____

Signature :

_____

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Witness:

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