orchidhealth
Exceptional, local healthcare

Controlled Substances Treatment Agreement

Patient Name: ______________________________

Patient DOB: _______________________________

Date Today: ________________________________

The purpose of this Agreement is to prevent misunderstandings about certain medications that you may be prescribed by our providers. This agreement is to help you, and your provider(s) comply with laws regarding controlled pharmaceuticals. ***(Please review & initial each of the following)***

___ I understand that this agreement is essential to the trust and confidence necessary in a practitioner/patient relationship and that my provider agrees to treat me based on this agreement.

___ If I break ***ANY*** terms of this agreement, my provider may begin a tapering program immediately or cease prescribing medication entirely. A drug dependence treatment program may be recommended or required.

___ I agree to never use ***ANY*** illegal substances or narcotics that have not been prescribed to me. Nor will I misuse or self-prescribe/medicate with legally controlled substances such as Alcohol.

___ I will not share my medications with anyone.

___ I will not sell my prescribed medications.

___ I will not attempt to obtain any controlled medications from any other providers. If I am given a controlled medication as part of treatment due to an acute injury or hospital admission, I agree to immediately inform my Orchid Health practitioner.

___ I agree to obtain my prescribed medications from ***ONE*** pharmacy. Please identify the Pharmacy where you will be filling your medication: ___________________. If for any reason I need to change my pharmacy, I agree to notify my Orchid Health practitioner immediately. They may or may not change the pharmacy based upon their own discretion.

___ I understand that my medication requires me to make an appointment every __ month(s), and that my medication will not be filled if I miss my appointment.

___ I understand that my prescription(s) are exactly like money: if either is lost or stolen, they ***CANNOT*** be replaced.

___ I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it first with my prescribing practitioner.

Patient Name: ______________________________

____ I agree to bring in my prescription bottles to every visit and I understand that "pill counts" might be instituted at any visit.

____ I understand that urine drug screens will be performed at least every 6 months, but that I might be required to have drug screens at any visit randomly.

____ I understand that there are risks to the medications I am being prescribed, and I have read and understand those risks.

____ My practitioner has reviewed with me my diagnosis, the instructions for use of my medications, my goals of treatment with this medication, alternatives to treatment and additional therapies that might be beneficial to me.

____ I have been given the opportunity to ask any additional questions about my treatment.

NOTICE OF RISK: The use of controlled substances may be associated with certain risks such as, but not limited to:

1. **Central Nervous System: Sleepiness, decreased mental ability and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.**
2. **Cardiovascular: Irregular or unsafe heart rhythm from mild to severe.**
3. **Respiratory: Slowing of respiration and the possibility of including wheezing, causing difficulty in catching your breath or shortness of breath is susceptible in individuals.**
4. **Gastrointestinal: Constipation is common and may be severe. Nausea and vomiting may occur as well.**
5. **Dermatological: Itching and rash.**
6. **Endocrine: Changes in testosterone levels (male) and other sex hormones (females); dysfunctional sexual activity.**
7. **Urinary: Urinary retention (difficulty urinating)**
8. **Pregnancy: Newborns may be dependent on opioids or other controlled substances and suffer withdrawal symptoms after birth.**
9. **Drug Interactions with altering the effect of other medications cannot be reliability predicted.**
10. **Tolerance: Increasing doses of drugs may be needed over time to achieve the same effect.**
11. **Physical dependence and withdrawal: Physical dependence developed within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized flu-like symptoms, abdominal cramps, and abnormal heartbeats. All controlled substances need to be slowly tapered off under the direction of your practitioner. BENZODIAZEPINES like Vallum (Diazepam), Xanax (Alprazolam), Klonopin (clonazepam) and Ativan (Lorazepam) can cause seizures if stopped abruptly after regular use.**
12. **Addiction (Abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.**
13. **Allergic reactions: Are possible with any medications. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.**
14. **Accidental Overdose: In some instances, controlled substances may accumulate, leading to respiratory difficulty, coma or death. This risk is increased by certain medical conditions, high dose opioid treatment, and other medications including tranquilizers, CNS depressants, alcohol, marijuana or other illicit drugs.**

This is an agreement between (Patient): ______________________________________ and (Prescriber): ______________________________ Concerning the Use of Opioid Analgesics, Benzodiazepines and other controlled substances, for the treatment of my chronic condition.

Diagnosis: ____

Medication and Strength: ____

Number of Pills/Month and Frequency: ______________________________________

Additional Comments: ____

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Termination Clause:

- ***The practitioner may terminate this Agreement at any time if the practitioner has cause to believe that I am not complying with the terms and conditions of this Agreement or have misrepresented or provided false statements concerning my reasons for needing the listed medications.***
- ***The practitioner may terminate the Agreement at any time, if I do not comply with the terms of this Agreement.***
- ***I understand that I may terminate this Agreement at any time knowing that I will not be prescribed future controlled medications by Orchid Health.***

Patient Signature: _______________________________________ Date: _______________

Practitioner Signature: ___________________________________ Date: _______________