



Controlled Substance Contract

I (patient): _____

My Provider: _____

Controlled Substance (Medications): _____

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

I voluntarily request my provider to treat my condition which has been explained to me as _____ (condition). I hereby authorize and give my consent to administer or prescribe the prescription(s) for dangerous and/or controlled substance(s) (medication(s)) as part of therapy or treatment for my condition.

It has been explained to me that these medication(s) may include opioid/narcotic, anti-anxiety, insomnia, ADHD, etc. drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. Alternative methods of treatment, possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs on less than 24 hour notice and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in my being discharged from my provider's care.

For female patients only:

_____ To the best of my knowledge I am not pregnant.
initials

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I understand the possible side effects of medication(s) and that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use. If I am pregnant or am uncertain, I WILL NOTIFY MY PROVIDER IMMEDIATELY.

For ALL patients:

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO:

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| 1. Constipation | 9. Depression |
| 2. Nausea or vomiting | 10. Impaired judgment &/or reasoning |
| 3. Excessive drowsiness or sleepiness | 11. Respiratory depression (slow or no breathing) |
| 4. Itching | 12. Impotence |
| 5. Urinary retention (inability to urinate) | 13. Tolerance to medication(s) |
| 6. Orthostatic hypotension (low blood pressure) | 14. Physical and emotional dependence, addiction and/or insomnia (inability to sleep) |
| 7. Irregular heartbeat | 15. Death |
| 8. Insomnia (inability to sleep) | |



I UNDERSTAND that it may be dangerous for me to operate an automobile or other machinery while using the medication(s) and I may be impaired during all activities, including work.

The goal of this treatment is for the management of my condition in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I am expected to participate in a functionally restorative program that may include physical/occupational therapy and/or other psychological counseling as prescribed by my doctor. I understand that I may withdraw from this treatment plan and discontinue medication use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I UNDERSTAND that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat my condition may be controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give informed consent.

CONTROLLED SUBSTANCE AGREEMENT:

The following agreements are made between the Patient and Provider, as identified above, and outline the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING: *(please initial each after reading)*

- _____ 1. This Controlled Substance Agreement relates to my use of any and all medication(s) to manage my condition as prescribed by my provider.
- _____ 2. All medication(s) and prescriptions for the treatment of my condition will be obtained from only my provider.
- _____ 3. Medication(s) for the management of my condition will be provided by my provider so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my provider's care and treatment.
- _____ 4. Discharge from my provider's care and treatment may be immediate for any criminal behavior.
- _____ 5. All medication(s) prescribed by my provider and other medication(s) prescribed by other providers must be obtained at only one (1) pharmacy. I will provide my pharmacist with a copy of this agreement at the request of my provider.
- _____ 6. I will use the medication(s) exactly as directed by my provider.
- _____ 7. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my provider.
- _____ 8. Use of illegal substances, alcohol, and other mood altering drugs can lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) at any time and without prior warning on less than 24 hour notice. Any evidence of use of illegal substances will lead to discontinuation of the medication(s).
- _____ 9. My provider may at any time choose to discontinue the medication(s) for the treatment of my condition.



- _____ 10. I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my provider.
- _____ 11. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.
- _____ 12. I will stop all other medication(s) for the management of my condition unless otherwise directed by my provider.
- _____ 13. I agree to inform my provider of any scheduled surgeries and / or procedures in a timely manner to allow any alterations of the medication(s) dosage.
- _____ 14. I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).
- _____ 15. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.
- _____ 16. I agree not to obtain or seek to obtain any other medication(s) from any other source (including Emergency Department, "urgent care clinic," etc.) without first contacting my provider. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my provider may lead to a discontinuation of the medication(s) and treatment.
- _____ 17. I understand that the State of Florida tracks information provided by pharmacies regarding all controlled substance prescriptions. My provider may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.
- _____ 18. I will notify my provider's office during office hours at least five (3) business days in advance before running out of medication(s) so the appropriate refills can be made. No controlled medications will be ordered when the office is closed.
- _____ 19. I understand that refills will NOT be ordered before the scheduled refill date even if my medication(s) runs out. When traveling, arrangements may be made in advance of planned departure date.
- _____ 20. If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my provider may try alternative medication(s) or may taper me off all medication(s). I will not hold my provider liable for problems caused by the discontinuance of the medication(s).
- _____ 21. I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., physical therapy, psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my provider to achieve increased function and improved quality of life.
- _____ 22. I understand and agree that a consult with or referral to, an expert may be necessary such as submitting to a psychiatric or psychological evaluation by a qualified provider.
- _____ 23. I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).
- _____ 24. I must keep all follow-up appointments as recommended by my provider or my treatment and / or medication(s) may be discontinued.



DEDICATED PHARMACY:

Name: _____

Location: _____

Phone: (_____) _____ Fax: (_____) _____

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of non-treatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.
3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

Signature Print Name

Date: _____ Time: _____ A.M. / P.M.

WITNESS/PROVIDER:

Signature Print Name