Controlled Substance Agreement

Controlled substance medications (i.e., narcotics, tranquilizers, barbiturates, pain pills, stimulants, sleeping pills, etc.) are especially useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, improve focus, and relieve suffering, thus improving function and/or ability to work. With my provider prescribing controlled substance medications to help manage my medical condition, I agree to the following:

_____1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if "I run out early," I understand that this medication **will not be replaced**, regardless of circumstances.

_____2. Refills of controlled substance medications:

_____ will only be made during regular office hours *Monday through Friday*, in person, every 3 months, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.

_____ will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____ I understand that I must call ahead at least 72 hours to schedule an appointment.

_____ I agree that I will be seen every 90 days, regardless of refill status.

_____3. It may be deemed necessary by my provider that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do attend such an appointment, my medications may be discontinued or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), then my medications will no longer be filled.

_____4. I agree to comply with urine testing and pill counts at every appointment, thereby documenting the proper use of any medications.

_____5. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other providers, pharmacies, medical facilities, and the appropriate authorities.

_____6. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco or alcohol. I must also comply with the treatment plan as prescribed by my provider.

_____7. I understand that the long-term advantages and disadvantages of chronic controlled substance use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances.

_____8. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____9. I understand that I will only see one (1) provider for this medication and will only receive the prescription from that one provider. I understand that receiving controlled substances from more than one provider will result in discontinuing the prescription and any further refills to be written.

____10. I understand that First Coast Family Medicine routinely checks E-FORCSE, a statewide controlled substance monitoring program.

____11. I understand that if I receive prescriptions for controlled substances from other providers or give any reason to suspect diversion from this agreement, then I authorize release of my medical records and any other evidence to appropriate legal authorities.

____12. I understand that if I demonstrate any signs or symptoms of addiction or abuse, then my prescriptions will no longer be written, and I will be referred to an addiction specialist.

____13. I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.

Controlled Substance Policy

I have read and understand the controlled substance medication policy for First Coast Family Medicine. I understand my responsibilities and my doctors' responsibilities for these medications.

Patient Name

Signature and Date