Controlled Substance Prescription Contract

Patient: _____ Date: _____

The purpose of this contract is to define the expectations between the prescriber, _____ and the patient regarding the use of controlled substances.

I understand that I have a chronic condition (ADD/ADHD, anxiety, chronic pain, insomnia, hypogonadism) necessitating the use of controlled substances. In addition, I understand that the use of controlled medications carries the risk of addiction as well as adverse effects/side effects from the medication. I understand that these medications may impair my ability to operate a motor vehicle or heavy equipment.

In order to reduce the chances of abuse of medications and the associated risks with taking these medications, certain parameters regarding the prescription are agreed upon:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive these controlled substance prescriptions from other medical providers, except as authorized by my provider.
3. I will not ask for early prescription refills except under the most adverse conditions.
4. No replacements will be provided for lost medications or prescriptions.
5. If an early refill is granted for reasons of travel, etc., the next refill will be delayed by an amount of time equal to the number of days early the refill is given.
6. I understand that my healthcare provider will need to see me for regularly scheduled visits to follow up on my chronic condition. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I will request medication refills as least 5 business days ahead of the time I will run out.
8. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my medications and I will notify my provider if I change pharmacies.
9. I consent to random drug testing.
10. No refills will be provided at night, on holidays, or on weekends. I will not request refills from on-call providers.

I have been informed I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combined use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death.

Failure to abide by these parameters will be grounds for termination of the prescription of controlled substances by _____ and may result in termination from this practice.

I have read, understand and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____