PRIMARY CARE INTERNISTS OF MONTGOMERY, PC
Contract for Controlled Substances

NAME: _____ DOB: _____ GENDER: M F

Controlled substances (i.e. opiates, tranquilizers, and barbiturates) 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 relieve pain to improve function and or ability to work, not simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions.

I also understand that I am responsible for any controlled substance. 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.

I will not request or accept controlled substances from other physicians or individuals while I am receiving such medications from my physician. Besides being illegal to do so, it may endanger my health. The only exception is when it is prescribed while I am admitted into a hospital.

Refills of controlled substances:

- Will be made only during regular office hours, in person, and only once each month during a scheduled office visit.
- Refills will not be made at night, weekends, or holidays.
- Will not be made if I "run out early", "lose my prescription", or "spill or misplace my medicine".
- I am responsible for taking the medication in the dose and frequency prescribed and for keeping track of the amount remaining.
- Will not be made as an emergency, such as on Friday because I suddenly realize that I will run out over the weekend. I will call at least 48 hours ahead if I need assistance with a controlled substance.
- 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 physician, will constitute a violation of the contract.

NAME/LOCATION OF PHARMACY:_____

I agree to comply with the random urine, blood, or breathe testing documenting the proper use of my medication as well as confirming compliance. 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 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 physician will advise me as knowledge and training advances and will make appropriate treatment changes.

It may be deemed necessary by my doctor more me to see a medication use 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 o refilled beyond a tapering dose to completion. I understand that if this specialist feels I am at risk for psychological dependence that my medications will no longer be refilled.

I understand that if I violate any of the above conditions, my controlled substance and/or treatment 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 physician, medical facilities, and other appropriate authorities.

I have read this contract and the same has been explained to me by my physician and/or other staff which he appointed. In addition, I fully understand the consequences of violating this contract.

DATE:_____

PATIENT SIGNATURE_____

WITNESS SIGNATURE_____

PHYSICIANS SIGNATURE_____