CHS Community Health Services
Your Partners for Better Health

AGREEMENT FOR LONG-TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

_____/_____/_____
TODAY'S DATE

_____ _____/_____/_____
PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

The use of (print names of medication(s))_____ is only one part of the treatment for:

(print name of condition—e.g., pain, anxiety, etc.) _____.

_____ (provider name) will be my designated provider for this medication.

The goals of this medicine are:

- To improve my ability to work and function at home.
- To help my condition(s), stated above, as much as possible without causing dangerous side effects.

Patient must initial each statement after reviewing.

_____ My provider has completed medication counseling which includes the following information:

1. If I drink alcohol or use street drugs I may not be able to think clearly, and I could become drowsy and risk personal injury.
2. Abuse of the medication can be dangerous, and I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance that I may become addicted.

I understand and voluntarily agree that:

_____ I will keep, and be on time for, all my scheduled appointments with my designated provider.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to my designated provider.

_____ The above prescription(s) will be filled only by my designated provider.

_____ I will make sure I have an appointment for refills.

_____ It is illegal to, and therefore will not, sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release of records form to let my designated provider speak to all other doctors or providers that I see. I will inform my designated provider of all other medicines that I take, and let him/her know right away if I have a prescription for a new medication.

_____ I will use only one pharmacy to fill the prescription for the above medication(s), unless my designated provider is notified ahead of time:

_____ _____
PHARMACY NAME PHONE NUMBER

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_____ I will not use illegal drugs such as heroin and cocaine. I understand that if I do, my treatment may be stopped.

_____ I will come to the office for drug testing and counting of my pills within 24 hours of being called.

_____ I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____ If my designated provider determines that the risks of taking this medication are greater than the benefits, said provider will change my prescription to wean off or decrease my medication dose.

_____ If my designated provider recommends to treat the cause of my conditions, as stated above, said provider will change my prescription to wean off or decrease my medication dose.

_____ I may lose my right to treatment in this office if I break any part of this agreement.

I, _____ (the designated provider), will help set treatment goals and monitor your progress in achieving those goals. I will also work with any other doctors or providers you are seeing in order to treat you safely and effectively.

_____
PATIENT NAME (PLEASE PRINT)

_____ _____/_____/_____
PATIENT SIGNATURE TODAY'S DATE

_____
PROVIDER NAME (PLEASE PRINT)

_____ _____/_____/_____
PROVIDER SIGNATURE TODAY'S DATE