Controlled Medication Agreement- San Mateo County Health System

Our goal is to treat your medical conditions effectively and safely. Controlled medications can be used to increase your ability to participate meaningfully in your daily activities, but they have several serious safety risks. This agreement is designed to prevent misunderstandings about the medication(s) that you are being prescribed. This is intended to provide for your safety, as well as to ensure that your provider is following ethical and legal standards of appropriate care.

By signing this, I ____________________________, agree to and understand that:

1. I am being prescribed a controlled medication for the treatment of pain or another condition. The purpose of this treatment is to increase my ability to engage in my daily activities, not to eliminate my pain, anxiety, or other condition. I may need to continue these medications on an ongoing basis, and I may not achieve a condition where I feel completely well.

2. The long-term use of controlled medications may result in the development of physical dependence on the medication. Should I need to suddenly decrease or discontinue the use of this substance, I may experience symptoms of withdrawal. Withdrawal from opioids and stimulants is uncomfortable, but not life-threatening. However, withdrawal from benzodiazepines could require medical attention.

3. The use of these medications is only one part of my therapeutic treatment regimen. I understand that I am required to comply with the other prescribed methods of treating my condition (therapy, specialty appointments, etc.). Not following recommendations may lead to my provider discontinuing the controlled medications.

4. I agree to take these medications ONLY as they are prescribed. I will not increase the frequency or dose of any medication without first discussing and gaining authorization from my provider. Controlled medications will NOT be refilled early.

5. In the event that an unplanned incident arises (acute injury, dental problems, stressor), I might need additional medication on a short-term basis. I will not simply increase the use of my current medication (which could lead to accidental overdose and death), but will contact my provider for suggestions on how to effectively and safely manage this problem. If this occurs when the clinic is closed I will contact the clinic within the first 24 hours the clinic is open.

6. If an acute incident occurs that requires me to seek medical attention outside my provider I will let the treating provider know I am on a controlled medication agreement. If a controlled medication is given to me by another provider for an acute issue I will let the Clinic know within one business day.

7. Refills for controlled medications will only be made with my regular provider’s clinic and may require me to come to the clinic monthly to pick up the prescription.

8. Refills will not be made in the evening, on weekends or in the Emergency Department/Urgent Care Clinic. I will not seek or obtain controlled medications from other sources (including other medical providers, friends, family, etc.)

9. I will safeguard my medications from loss or theft. Lost or stolen medications will not be refilled.

10. These medications are for my use only. I understand that sharing, trading or selling these medications is against the law.
11. I agree to abtain from alcohol or illicit substances while taking any controlled medications as I understand that it is very dangerous. I will submit to random blood and/or urine tests when requested to determine my compliance with this agreement. Test will occur at least yearly.

12. I will ONLY fill my prescriptions at ________________________________ Pharmacy
   Phone: ________________________________ Fax: ________________________________

13. I authorize my provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of possible misuse, sale or other diversion of my medication. My provider may provide a copy of this contract with my pharmacy. I agree to waive my right of privacy or confidentiality with respect to these authorizations.

14. If I break any part of this contract, my provider reserves the right to stop providing my controlled medications. In this case, I will consult with my provider to determine the next steps for achieving the best therapeutic outcome - with or without controlled medications.

15. This contract is modifiable and flexible and may be altered or discontinued after discussion with my provider. Any changes will be initialed and dated.

16. My provider can discontinue any and all controlled medications at any time based on any medical concern, suspicion or belief that I, as a patient, maybe misusing the medication. My provider may also stop any or all controlled medication if they no longer are effective or that continuing the controlled medication is causing me more harm in treating my overall health.

17. At all times, I agree to treat all staff calmly and with respect.

18. OTHER:__________________________________________________________
    ____________________________________________________________
    ____________________________________________________________

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>#/week, month</th>
<th>Start Date</th>
<th>Stop Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medications**

**Non Medication Therapeutic Treatment Regimen**

In addition to medications, my treatment includes: (PT, psychotherapy, other appointments, etc)

1. _________________________________________________________________
2. _________________________________________________________________
3. _________________________________________________________________

______________________________________________________________
Patient/Guardian Signature                                           Provider Signature

Date signed: ______________________________

Will readdress pain by __________________ (date). If no date is placed we will readdress pain agreement within 2 years of signing or if a new provider becomes responsible for treatment.

Last modified 9/1/2015