QUAKER MEDICAL ASSOCIATES

Controlled Substance Agreement

DATE:

NAME: **Date of Birth :**

The purpose of this agreement is to protect your access to controlled substances and prevent misunderstandings about certain medications you will be taking. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. These drugs have potential risk for abuse or diversion, the extent of this risk is not certain.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing any controlled substances.
In this case, my doctor will taper off the medicine, as necessary, to help avoid withdrawal symptoms. My doctor may recommend a drug-dependence treatment program.

I will communicate fully with my doctor about the character and intensity of my pain or symptoms. I will communicate how well the medicine is helping.

I will not use any illegal controlled substances- marijuana, cocaine, etc.

I will not share, sell, or trade my medication with anyone.

I will not attempt to obtain controlled medications, including opiates, stimulants, or anti-anxiety medicines from any other doctor. I will notify my doctor if another physician changes or suggests changes to my medicines. I will also notify my doctor of any possible adverse effects I experience from any medications that I take.

I will safeguard my medicine from loss or theft. Lost or stolen medications will NOT be replaced.

I agree that refills of my prescriptions will be made only at the time of an office visit or during regular business hours. No refills will be available during evenings, weekends, or holidays. Early refills generally will not be given. I understand that refills require a 48 hour notice. No controlled substances will be refilled on Fridays.

I agree to use **(pharmacy name)** ; **(phone number)** for filling my controlled substance medication. I will notify the office if a need for change in pharmacy occurs.

I authorize this physician/office to discuss all diagnostic and treatment details with dispensing pharmacists or other medical professionals involved in my care, for the purpose of maintaining accountability.
I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my controlled substance. I authorize my doctor to provide a copy of this agreement to my pharmacy, if requested. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations. If responsible legal authorities have questions concerning your treatment, these authorities may be given full access to our records of controlled substances administration.

I agree that I will submit to periodic and random blood or urine test if requested by my doctor to determine compliance with my medication program. This test may be requested at the time of a refill. When called upon by the office, I understand that I have 24 hours to report and failing to do so may jeopardize any further refills.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. It may also jeopardize future prescribing of this medicine.

I will bring all unused medicine in original containers to office visits.

It is understood that failure to adhere to these policies may result in danger to my life and health, referral for further specialty assessment or discharge from my doctor's practice. My doctor may also elect to decrease or discontinue prescribing these medications. If this occurs, my doctor may choose to taper the medicine over a period of several days, to avoid withdrawal symptoms when discontinuing it.

I agree to follow these guidelines. All of my questions and concerns regarding treatment have been adequately answered.

Patient signature

Physician signature