



NANCY TACTUK, M.D.

### CONTROL SUBSTANCE USE CONTRACT

I understand that treatment by Crimson Internal Medicine, LLC may include an attempt to manage my pain and that some of the medications needed may carry a risk of causing addiction. Because of this, special care must be taken in their use.

As a result, I, \_\_\_\_\_ agree to the following:  
PLEASE PRINT NAME

1. That controlled substances prescribed will be taken exactly as directed, with adjustments made only if and as instructed.
2. There are no early refills or replacement of lost prescriptions, as federal law prohibits the writing of more than a certain number of pills at a time, and doctors and pharmacists are held accountable.
3. Attempts at altering prescriptions, selling medications, or obtaining narcotics from sources other than Dr. Tactuk will end treatment immediately.
4. Medications are given as part of an overall treatment program, and I will do all in my power to cooperate and participate in the range of nonmedicinal efforts to be undertaken.
5. When there are no alternatives other than to manage my symptoms with long term use of controlled substances, I agree that regular attempts to reduce dosage and/ or develop alternative approaches to functional comfort will be part of the plan, and I will cooperate with them.
6. I may be tested randomly for controlled substance that was prescribed to me. If the test results show that I have not been taking my medications correctly, I will be dismissed as a patient of Crimson Internal Medicine, LLC.
7. No controlled substances will be refilled on Friday or on weekends.

I have read, understood, and agree to these statements.

\_\_\_\_\_  
Signature Date  
\_\_\_\_\_  
Witness

WE ASK ALL PATIENTS TO SIGN THIS FORM, EVEN THOUGH YOU MAY NOT BE CURRENTLY TAKING A CONTROLLED SUBSTANCE.