Controlled Substance Agreement

Medicine(s)/Controlled substance(s): _____.[1]

Number and frequency of refills ____ or _____	Refills continued as appropriate upon reevaluation of patient by doctor.

This form is to make a contract for you and your doctor. It is about the medicine you take for pain. It is to help you and your doctor follow the law about a type of prescription medicine called controlled substances. On this form, "medicine" or "medicines" means a controlled substance.

I, _____ am aware and agree to the items below:

1. If I break the rules of this contract, my doctor may decide not to prescribe medicine for me. My doctor may ask me to find a new doctor. Or my doctor may refer me to a treatment program, which I agree to attend.

2. I will describe my pain to my doctor. I will explain how the pain affects my life. I will tell my doctor how well the medicine works to stop the pain.

3. I will keep all scheduled visits with my doctor. I will call ahead if I need to cancel. This rule may be changed in an emergency.

4. I will only get prescriptions from the doctor who signs this form, unless this doctor authorizes another doctor to prescribe them. Dr. Rodwick authorizes a covering physician (Dr. Linder, Dr. Grenz, Dr. Browne-King, or Dr. Joshi) to prescribe my medicine when Dr. Rodwick is not available.

5. I will not get any pain medicine from another doctor, unless I tell my doctor and get approval. If I get pain medicine from another site such as an emergency room, hospital, or nursing facility, I will tell my doctor right away.

6. I will not share, sell, or trade my medicine.

7. I will keep my pain medicine safe from loss, theft, or access by others. I will keep the medicine away from children and people who could be harmed by it. If I lose my medicine it will not be replaced. If my medicine is stolen my doctor may replace it, but only if I show my doctor a police report.

8. I agree to urine and blood drug screening tests, if my doctor requests them. My doctor may consider this contract broken if the test results show illegal drugs or medicine. This contract may also be broken if the test results show medicine that was not prescribed by my doctor or if medicine is not being taken as prescribed.

9. I agree that I will use my pain medicine in the amount prescribed per day. If I use more than what is prescribed, I will be without medicine for a period of time.

10. I agree that orders for refills of my prescriptions will be made only at the time of an office visit or during office hours. Orders for refills will not be given after hours, on weekends, or on holidays.

[1] Additional prescribed medicine(s)/controlled substances(s) are listed at the bottom of page 2.

11. I agree to use only one pharmacy for filling prescriptions of pain medicine. I will give the name, address, and phone number of that pharmacy to my doctor. I will not use more than one pharmacy.

12. I know and agree that my doctor may provide a copy of this form to my pharmacy. My doctor may discuss my treatment and use of medicine with the pharmacy staff.

13. If referred by my doctor, I agree to be seen and treated by a pain management doctor, an addiction medicine specialist, a mental health addiction facility, or other provider. I know and agree that my doctor may discuss my treatment and use of medicine with these providers.

14. I know and agree that my doctors and pharmacy will work together to the fullest extent allowed by law with any city, county, state, and federal law enforcement agency and this state's Board of Pharmacy. They make look into any possible misuse, sale, or sharing of my pain medicine.

15. This contract will remain in effect as long as my doctor prescribes any of the medicines listed on this contract. I am bound by the terms of this contract as long as I take at least one of the medicines prescribed under this contract.

I have read this contract, understand it, and have had all of my questions answered. I agree to follow the terms of this contract.

Signed: _____	Doctor Signed: _____
Print Name: _____	Print Name: _Barry M. Rodwick, M. D.___
Date: _____	Date: _____

Circle one: patient / legal representative (if one is present)

If signed by someone other than the patient,
state your legal relationship to the patient: _____

If needed, additional medicine(s)/Controlled substances(s):

Medicine(s)/Controlled substance(s): _____.

Number and frequency of refills ____ or _____	Refills continued as appropriate upon reevaluation of patient by doctor.

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