*** REQUIRED INFORMATION**

CONTROLLED SUBSTANCE PATIENT-PROVIDER AGREEMENT

THE USE OF ANY CONTROLLED MEDICATION IS ONLY ONE PART OF TREATMENT FOR MY PSYCHIATRIC HEALTH.

THE GOALS FOR USING THIS MEDICINE ARE:

- To improve my ability to work or function at home.
- To help my problem as much as possible.

PROVIDER RESPONSIBILITIES

- To make sure this medicine is helping and not hurting you.
- To NOT continue medicines prescribed by others unless they are safe and are the best treatment for your problem.
- To routinely check the state Prescription Monitoring Program, to see the medicines that you are getting from me and others.
- To work with other specialists to make sure you are getting the best treatment for your problem.

PATIENT RESPONSIBILITIES

- I will follow the treatment plan including keeping all appointments set up by my provider. For example these may include primary care, physical therapy, mental health, addiction treatment, and pain management.
- I am responsible for my medicines. I will not share, sell or trade my medicine.
- I will keep my medicine in a safe place where no one else will be able to take them. They could be very dangerous to others, especially children.
- I will not take anyone else's medicine.
- I will not take extra medicine.
- I will dispose of the medicine properly.
- I understand that my medicine will probably not be replaced if it is lost, stolen, damaged or used-up sooner than prescribed.
- I will bring the original pill bottles with all unused pills of this medicine to each clinic visit for pill counts. This includes visits with nurses or my provider.
- I will come in for a pill count and urine drug test anytime I am asked to do so, even if I don't have a clinic appointment on that day.
- I agree to give a urine sample for drug tests on the day it is requested whenever I am asked.

- I will not use any street or illegal drugs. I will not use any medications that have not been prescribed for me.
- I will not drink alcohol while taking this medicine unless my provider says it is safe to do so.
- I understand that use of this medicine is a test or trial. My provider will continue this medicine only if the medicine is helping and not hurting me.
- I will treat all people working in the clinic with respect.

PRESCRIPTIONS FROM OTHER PROVIDERS

If I get a pain medicine, sleep or anxiety medicine or a stimulant medicine from someone outside of primary care such as a dentist, psychiatrist or emergency room provider, I will tell my provider or nurse the next time I am in clinic. I will bring this medicine to Dr. Vera N. Okoye in the original bottle even if the bottle is empty.

REFILLS

- Refills will be available during regular office hours.
- No refills for this medicine on nights and holidays.
- No early or emergency refills may be made.
- I will pick up my refill prescription myself whenever possible. At rare times I will notify the clinic before the prescription is due, that a family member or friend will pick up the prescription for me.

PRIVACY

While I am taking this medicine, my provider may need to contact other providers or family members to get information about my care and use of this medicine.

STOPPING THE MEDICATION

If I do not follow this agreement, or if my provider decides that this medicine is hurting me more than helping me, this medicine will be stopped in a safe way.

I HAVE BEEN TOLD ABOUT THE POSSIBLE RISKS AND BENEFITS OF THIS MEDICINE

- The medicine may help my problem but may cause other problems like addiction, overdose and death.
- When I start this medicine, when my dose is increased or if I drink alcohol or use street drugs, I may not be able to think clearly. I could become sleepy and have an accident.
- I may get addicted to this medicine. This could cause me to get into trouble and have problems at home or work.

- If I or anyone in my family has a history of drug or alcohol problems, I will have a higher chance of addiction to this medicine.

☐ I have talked about this agreement with my provider and I understand it. I have had an opportunity to ask questions about the potential benefits and risks of this medicine.

PARENT'S NAME *

Enter name here

PARENT'S SIGNATURE *

DATE

Clear

PROVIDER'S NAME *

Enter name here

PROVIDER'S SIGNATURE *

DATE