Lake Street Family Physicians, Controlled Substance Agreement

For patient safety and to comply with regulations regarding the prescription of controlled medications, Lake Street Family Physicians, has adopted the following policy.

In this policy, controlled medications refer to medications which are monitored by the Drug Enforcement Agency, including (but not limited to) the following: hydrocodone, tramadol, Xanax, klonopin, Ativan, Concerta, Adderall, and Ritalin.

1. I understand that chronic use of controlled medications holds a risk of psychological and/or physical dependence, and it is only one part of a comprehensive treatment for my medical condition.
2. As part of the treatment plan, I will follow through with any other treatment recommendations made by my provider, including physical/occupational therapy, counseling, and/or other referrals.
3. I will only take the medication as prescribed and changes will only be made after discussion with my provider. **No early or emergency refills may be made** if it is used up sooner than prescribed.
4. I will safeguard my medication from loss, theft, or unintentional use by others. **Lost or stolen medications will not be replaced.**
5. I will not attempt to obtain any controlled medications from any other practice unless approved by my provider. This includes prescriptions from Emergency Room or Immediate Care visits.
6. I will not share, exchange, sell my medicine.
7. I will not use illegal drugs including marijuana, cocaine, heroin, etc.. I will not use any controlled medication that is not prescribed for me.
8. I understand that my provider may request samples for random blood or urine tests. If I fail to provide a sample when asked or if the results are unsatisfactory, I may forfeit my right to continue receivingthe medication.
9. I may be asked to present with my medication in their original bottle for a pill count at any time.
10. If my provider feels that the medication is no longer effective or is concerned about any adverse effects including addiction, my provider may adjust or stop my medication in a safe way.
11. I agree that refills of my controlled medications will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on the weekends.**
12. I agree to fill the controlled medication at one and only one pharmacy.

    Pharmacy name/phone #: _____

13. I understand that my provider may contact other caregivers to get information about my care and/or use of this medication.
14. I understand that LSFP will be verifying my prescription history by checking the Prescription Monitoring Program periodically.
15. I authorize LSFP 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.
16. All my questions regarding use of controlled medications and this agreement have been answered. I understand that my controlled medication may no longer be prescribed at LSFP if I break any of these rules.

_____	_____	_____
Patient Signature	Patient name (printed)	Date
_____	_____	_____
Patient's guardian Signature	Patient's guardian name (printed)	Date
_____	_____	_____
Provider Signature	Provider name (printed)	Date