McLaren Macomb

CONTROLLED MEDICINES AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.

TERMS OF THE AGREEMENT:

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my doctor will stop prescribing controlled medicines.

I understand that this agreement includes all controlled medicines scheduled II-V as categorized by the U.S. Federal regulations. This may include, but is not limited to, drugs referred to as Narcotics, ADD/ADHD Medications, Sleep Medications, Benzodiazepines, etc.

I will communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve the symptoms.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., or prescription drugs not prescribed to me, and agree that I will submit to a random blood or urine test if requested by a provider to determine compliance with my program of controlled medication management.

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

I will not attempt to obtain any controlled substances, including opioid medicines, controlled stimulants, or anti-anxiety medicines, from any other doctor without coordination of care between doctors.

I will safeguard my medicine from loss or theft. I understand my doctor may not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my medicine, I understand my doctor will discuss this with me and may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of controlled medicines. I agree to these additional controls, which I understand include limitations on my supply of controlled medicines.

I agree that refills of my prescriptions for controlled medicines will be made only at the time of an office visit or during regular office hours because an evaluation of my circumstance or condition must be made. No refills will be available outside of normal business hours.

I agree to use _____ Pharmacy, located at _____ , for filling prescriptions for all of my controlled medicines.

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 medicine for a period of time.

I understand that I am required to see my healthcare provider in a face-to-face appointment at least _____ times per year.

I understand that any provisions not followed in this Agreement could be grounds for discharge from care.

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

All controlled substances carry the risk of addiction.

This Agreement is entered into on this _____ day of _____, _____. _____

Patient: _____ Provider: _____

Authorized Representative: _____ Relationship: _____

Witness: _____

PATIENT
NAME:

DATE OF BIRTH: