CONTROLLED SUBSTANCE AGREEMENT

BW PRIMARY CARE, LLC **Patient:_____ DOB_____**

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain/anxiety/ADHD that have addictive/abuse potential. This is to help both you and your primary care provider comply with the law regarding controlled pharmaceuticals. I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my healthcare provider undertakes to treat me based on this agreement. As part of your treatment plan, you may or may not be prescribed a controlled medication at the sole discretion of your provider at BW Primary Care.

I realize that it is unlikely that any medication will completely take away symptoms. I may be prescribed controlled medications in certain circumstances, provided that I follow the terms of this contract. Your provider and you have aimed to set realistic goals for pain/anxiety and overall function.

For opiates specifically: I understand that the possible complications of chronic narcotic therapy include:

- ❑ chemical dependence or tolerance to medication (addiction)
- ❑ sleepiness or drowsiness
- ❑ constipation
- ❑ nausea/vomiting
- ❑ slowed respiration
- ❑ withdrawal symptoms from abruptly discontinuing medication

If I take more medication than is prescribed, a dangerous situation could result, such as coma, organ damage, or even death. If I become pregnant, there are known risks to the unborn child which include narcotic addiction and the baby experiencing narcotic withdrawal at birth. I am aware that addiction is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I agree to disclose to my provider my complete and honest drug history and that of my family, to the best of my knowledge. My provider and I have clearly discussed the risk factors of opioid therapy. Our goal is to use this therapy for short term treatment if possible.

I will comply with regular appointments to discuss my function. I will share all current (and changes to) medications with my prescriber, and I am aware that my provider is using prescription drug monitoring program (PDMP) data as well to monitor for prescribed medications. If I opt out of CRISP (Chesapeake Regional Information System for Patients) and the PDMP, then I will no longer be able to receive controlled substances from BWPC. Medication refills will only be given to those individuals who are being treated at BW Primary Care. Failure to show for follow-up visits constitutes a breach of this agreement and may result in termination from this practice.

Refills on controlled medicine will be prescribed by our providers during follow up appointments and in person whenever possible.

You agree to only use one pharmacy for refills; you may choose which pharmacy.

My Pharmacy is: Name: _____

Pharmacy Phone Number/Location: _____

Patient _____DOB: _____

I AGREE TO THE FOLLOWING:

- I must keep all regular follow up appointments as recommended by my provider. This may be monthly. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from BW Primary Care. SPECIFIC FOLLOW UP REQUIRED: every _____months.
- I agree to random drug screens (urine and blood tests) to identify the level of medication in my body. A urine sample will be obtained with **EACH** visit but may not be submitted. I understand my insurance company may not cover these tests and I am financially responsible.
- I will notify my provider if I receive a prescription for other controlled medications from another source other than BW Primary Care.
- I will ask for appropriate refills of narcotic/controlled medications during office visits and/or regular business hours. I am aware that I need to make sure I have enough medication to get through the weekend or holiday hours.
- I agree to take the narcotic/controlled medication exactly as instructed by my prescriber.
- I agree that the provider will NOT replace any lost, stolen, or inaccessible narcotic medications for any reason.
- I understand the difference between physical dependence and addiction, and am aware that abruptly stopping my medication may cause withdrawal symptoms.
- If I am a female in childbearing years, I agree to use effective birth control means, and if I do become pregnant, I will notify my medical provider immediately.
- If addictive behavior occurs, I agree to be discharged, and seek and obtain care immediately from an addiction specialist or psychiatrist and will follow prescribed treatments, including detoxification if recommended.
- I understand the goal of this therapy is to decrease pain/anxiety/other and increase my ability to maintain daily function, thereby improving the quality of my life. I understand if these goals are not being met, in the opinion of my provider, I may be discharged.

YOUR CONTROLLED PRESCRIPTION WILL BE DISCONTINUED IF YOU BREAK ANY OF THE FOLLOWING RULES OR AT THE DISCRETION OF THE PRESCRIBER:

- Use more than was prescribed (run out early).
- Get pain/controlled medicine from any other physician or person without obtaining authorization in writing to do so by my provider at BW Primary Care.
- Use illicit drugs.
- Use the medication in a way that it was not prescribed.
- Exhibit deceitful behavior or provide false information.
- Make repeated calls to this office to obtain medication.
- Call after hours or on weekends or holidays to obtain medication or refills.
- Sell your drugs or give them to another person.
- Alter a prescription.

I have read the preceding information and agree to abide by these rules. I understand that failure to follow these rules will result in my being discharged from this practice and risk prosecution as directed by state and federal laws.

_____	_____	_____
Patient Signature	**Print Name**	**Date**