Controlled Substance Agreement and Informed Consent

The purpose of this agreement is to provide you with information regarding the risks and benefits of using controlled substances. It also specifies your responsibility in the proper use of these medications and the role you will play in your treatment. The overall goal of treatment is to provide the best quality of life possible given the realities of your clinical condition. I understand that I have the following responsibilities:

____ I will take the medications at the dose and frequency only as prescribed.

____ I will not increase or change how l take my medications without the approval of this healthcare provider.

____ I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or weekends.

____ I will obtain all refills for these medications only at my designated pharmacy with full consent for my provider and pharmacist to exchange information in writing or verbally.

____ I will not request any pain medications or controlled substances from other providers. Should I received prescriptions for non-controlled substances and/or begin any supplements and/herbs, I shall immediately notify my provider.

____ I will inform my other health care providers that I am taking controlled substances and of the existence of this agreement. In the event of emergency, I will provide this same information to emergency department providers. I will inform this provider of any Emergency Room (ER) visit within 48 hours of discharge from the ER. I understand and give my permission that all treatment providers can communicate with each other and discuss my care and treatment.

____ I will protect my prescriptions and medications and will keep them safe and secure. I understand that lost, stolen, accidently destroyed or misplaced prescriptions will not be replaced. I will keep medications only for my own use and will not sell, lend, share, or give any of my medication to others. Failure to uphold this term may constitute a criminal offense. I will keep all medications away from children. I agree to comply with all components of my overall treatment plan including medical, psychological, or psychiatric assessments recommended by

my provider. I will actively participate in any program designed to improve function, including social, physical, psychological, and daily or work activities

____ I will not use illegal or street drugs or another person's prescription. I will use no alcohol or other sedating medications without discussing it with this provider. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, and I agree to follow through. If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

____ I will consent to drug screening which may include urine, blood, hair, saliva, or nails to conduct a laboratory test to check to see what drugs I have been taking. A positive screen for medications not prescribed may result in termination. No evidence of the prescribed medication may be grounds for termination. Refusal to test may be grounds for termination.

____ I will bring in my medications to each visit in their respective prescription containers and remaining medication to determine if medications are being taken as prescribed.

____ I understand that my provider will verify through the Arkansas prescription monitoring database for controlled substances. Receiving controlled substances from another provider may be grounds for termination.

____ I will keep all my scheduled appointments. If l need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled.

____ I understand that this provider may stop prescribing controlled substances if I do not show any improvement in anxiety or my activity has not improved; if I develop rapid tolerance or loss of improvement from the treatment; if I develop significant side effects from the medication; and/or if l violate any one of the above conditions.

____ I understand that driving while taking the controlled substance as prescribed is driving under the influence under currently law and I understand that I have been directed not to drive while taking the controlled substance.

Informed Consent: Controlled substances shall be used in a judicious manner due to their substantial risks. These medications are potentially dangerous, and the side effects and risks are discussed with you. Side effects/risks include but are not limited to the following:

• Allergic reactions
• Sedation
• Somnolence
• Respiratory depression (slow breathing)
• Dizziness
• Suppression of menstrual cycle
• Hormonal imbalance
• Constipation
• Itching
• Physical dependence

- Confusion
- Nausea
- Vomiting
- Urinary retention
- Tolerance
- Addiction
- Death

____ Psychological dependence is the feeling of well-being produced by long-term use of some medications; absence of the medication may produce feelings of anxiety, irritability, depression or cravings.

____ Tolerance is a physical state resulting from regular use of a medication, which an increase dosage is needed to produce the same effect. Tolerance does not always occur using controlled substances and does not, alone, indicate addiction.

____ Addiction is the lack of control over drug use, including taking drugs more often than prescribed by a provider. Genetic, psychosocial, and environmental factors may contribute to the addiction.

____ Usually, most side effects of controlled substance use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated, if necessary.

____ If the decision is to discontinue controlled substance therapy, you agree to wean off the medication rather than abrupt discontinuation in order to prevent withdrawal symptoms, which can be serious or even life threating depending on the medication.

____ Controlled substances may cause drowsiness. You should not drive or operate heavy machinery while taking controlled substances.

____ Alcoholic beverages should be avoided as it may cause dangerous side-effects with your controlled substances.

____ Taking doses higher than prescribed and directed; taking doses with alcohol; taking doses with other medications may cause a fatal overdose.

____ I understand that no guarantee has been made to me with regard to my treatment. My provider cannot guarantee a cure of any condition. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I hereby give my informed consent to be prescribed and use controlled substances for my condition and acknowledge receipt of this agreement. I have been given a copy of this document.

Name (Print): ____

Signature: ____ Date: _______________________