Patient_________________________________ Medication Agreement (AB 474)
Chart Number__________________________

CONTROLLED SUBSTANCE AGREEMENT

PATIENT:______________________________ **PROVIDER:** ______________________

MEDICATION(S): ____

This agreement is important for you to make sure you will have a safe and controlled pain treatment plan.

Your medicine(s) has a high potential for abuse, and can be dangerous if used in the wrong way. You need to understand the risks that come from use of pain medicines.

Please read each statement below. Tell me if you don't understand any of these statements.

Here are the rules about using this medicine, refills, and health risks, and reasons why your pain treatment may have to be stopped.

This agreement will be part of your medical record.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. This Controlled Substance Agreement relates to my use of any and all medication(s) to manage my condition as prescribed by my provider.
2. All medication(s) and prescriptions for the treatment of my condition will be obtained only my provider during scheduled appointments.
3. I will take my pain medicine exactly as directed by my healthcare provider.
4. I will be honest with all my healthcare providers if I am using street drugs.
5. I will get all of my medicine(s) from all of my providers at only one (1) pharmacy. I will provide my pharmacist with a copy of this agreement at the request of my provider.
6. I will be honest about all medicines I use, including medicines from stores and herbal medicines.
7. I will be honest about my full health history.
8. I will tell my provider if I go to an emergency room for any reason.
9. If I get pain medicine from an emergency room I will tell my healthcare provider.

10. I will call my provider if I am prescribed any new medicine.

11. I will call my provider if I have a reaction to any medicine.

12. I will tell all other healthcare providers that I have a pain medication agreement.

13. I will tell emergency room staff that I have a pain medication agreement.

14. I will take drug tests and other tests when I am told to do so.

15. I will go to office visits when I am told to do so.

16. I will go to physical therapy when I am told to do so.

17. I will go to counseling when I am told to do so.

18. I will follow directions for all treatment.

19. I will show up on time for all appointments.

20. I will make an appointment for refills before I run out of medicine.

21. I will tell my healthcare provider if I will be out of town so that I can get my refills.

22. I will get past health records from other offices when needed; I will deliver these records by hand if needed.

23. I will give permission to my healthcare provider to talk about my treatment with pharmacies, doctors, nurses, and others who are helping me.

24. I will give permission to any healthcare provider to get information from this office about my health and my pain treatment.

25. I will take responsibility if I overdose myself accidentally or on purpose.

26. I will tell my healthcare provider if I plan to become pregnant.

27. I will tell my healthcare provider if I am pregnant while I am taking pain medicine.

28. I will only take this medicine the way I was told to take it.

29. I will NOT share or sell or trade any of my medicine.

30. I will NOT drink alcohol or take street drugs while I am taking paid medicine.

31. I understand that I can NOT call this office or my healthcare provider to have my medicine refilled over the phone.

32. I will NOT go to the emergency room or to other doctors for more pain medicine or other drugs.

33. I know that when I drive a car I must be fully alert and that when I use machines I must be fully alert. I understand that pain medicines make me less alert. When I am taking pain medicines I need to be sure that I am alert. I need to be sure that it is safe for me to drive a car or use a machine.

34. I will NOT stand in high places or do anything that could hurt others after I have taken pain medicine.

35. I will NOT leave my medicine where it can be stolen or where others can take it.

36. I will NOT leave my medicine where children can find it.

37. I will NOT suddenly stop taking my medicine; I know that if I do this I can have withdrawals.

38. When using a pharmacy I will use the same pharmacy for all of my medicine; that pharmacy is:____

39. I will NOT ask for early refills or more pain medicine, even if I lose my medicine.

40. I know that pain management may include other treatment, including some treatment that may not include medicine.

41. I know that pain medicine will probably not get rid of all of my pain. Pain medicine can reduce my pain so that I can do more and have a better life.

42. Part of my treatment is to reduce my need for pain medicine.

43. If the pain medicines work, I will continue to use them. If the pain medicine does not help me, it will be stopped.

44. My medicines will not be replaced if any of the following things happen: Medicine is lost. Medicine gets wet. Medicine is destroyed.
45. If my medicine is stolen I might be able to get more medicine if I get a police report about the medicine getting stolen.

46. Any of my healthcare providers can find out from the Nevada Prescription Drug Monitoring Program about other medicines I get from any other pharmacy in

California. This is called a PMP Report.

47. I may be sent to another provider for drug abuse or addiction help if I need it.

48. Pain medicine can be addictive. This means that my body may need more and more pain medicine or that it can be hard for me to stop taking this medicine.

49. If I suddenly stop using the medicine, I can get withdrawals.

50. If I use too much pain medicine, I can end up with health problems. I could die.

51. If I mix medicines, I could also end up with health problems. I could die.

52. Here are some of the things that could go wrong if I use too much medicine or mix medicines: overdose, addiction, constipation, vomiting, sleepiness, slower reflexes, nausea, difficulty with urination, confusion, itching, problems with sex, dry mouth, depression, trouble breathing, death.

Cause for Dismissal from Treatment

I know that my pain medicine(s) may be stopped if I break any part of this agreement. My signature below means that I have read and agree to everything listed in this agreement. I am signing this to say that I understand and agree to abide by this agreement.

Date:________________________________ Time:_________________a.m./p.m.

____
Signature of Patient/Patient Representative

Print Name:____

If signed by someone not the patient, explain relationship:__________________________
(e.g.,parent/guardian, conservator)

Provider/Witness: _____________________________________
Signature

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