HEALTH CLINICS OF UTAH

CONTROLLED SUBSTANCE AGREEMENT USING PRESCRIPTION OPIOIDS AND OTHER CONTROLLED SUBSTANCES

PATIENT NAME: _____

PRESCRIBER NAME: _____

THE PURPOSE OF THIS AGREEMENT IS TO STRUCTURE OUR PLAN TO WORK TOGETHER TO TREAT YOUR CHRONIC PAIN AND OTHER CONDITIONS REQUIRING CONTROLLED SUBSTANCES. THIS WILL PROTECT YOUR ACCESS TO OPIOID PAIN MEDICATIONS AND OUR ABILITY TO PRESCRIBE THEM TO YOU.

I (patient) understand the following (initial each):

____ Opioids/controlled substances have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

____ Goal for improved function: See Initial Evaluation and subsequent follow-up visits.

____ Opioids/controlled substances are being prescribed to make my pain/symptoms tolerable but may not cause it to disappear entirely. If this goal is not reached, my medical provider may end the trial.

Goal for reduction of pain/symptoms: See Initial Evaluation and subsequent follow-up visits.

____ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.

____ Using opioids to treat chronic pain will result in the development of physical dependence and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, depressed mood, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

____ There is a small but significant risk that opioid psychological dependence (addiction) can occur. If it appears that I may be developing addiction, my medical provider may determine to end the trial.

____ The patient education as discussed above applies to all controlled substances, though usage and adverse effects (including dependence and addiction) of medications vary. Your medical provider will address other controlled substances if they are a part of your treatment program.

I agree to the following (initial each):

____ I agree to take medications as prescribed. Using medications at a faster rate or increased dose other than prescribed may result in death.

____ I agree to have regular office visits as decided by my medical provider. I understand that this agreement will be null and void if more than 15 days elapse past my anticipated, regular appointment time.

____ I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.

____ I agree not to share, sell, or in any way provide my medication to any other person.

____ I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my medical provider may check the Utah Controlled Substance Database at any time to check my compliance.

____ I agree not to seek or obtain **ANY** mood-modifying medication, including pain relievers or tranquilizers from **ANY** other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

____ I agree to refrain from the use of **ALL** other mood-modifying drugs (prescription and illicit), including alcohol and marijuana. My medical provider may prescribe other controlled substances as part of my treatment plan.

____ I agree to submit to random urine or blood for drug testing at my prescriber's request. I understand that it is my responsibility to pay for drug screening if self pay or it is not covered by insurance. I agree to have random pill counts at my prescriber's request. I must have access to a telephone and able to be reached by telephone within 24 hours. Drug testing and pill counts verify compliance with my treatment plan. If I cannot produce urine or blood at the time requested, this will be grounds for termination of pain management services. I agree to being seen by an addiction specialist if requested.

____ I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time. In consideration of my treatment goals, I agree to help myself by following better health habits, including exercise, smoking cessation, and weight control.

____ I agree to attend and participate fully in a mental health evaluation and/or treatment for mental health disorders (i.e. depression, anxiety, etc) as may be recommended by the prescriber at any time

____ I understand that this contract also applies to any and all controlled substances that are part of my total treatment program, not just limited to pain management.

I understand that ANY deviation from the above agreement will be grounds for termination of controlled substance prescribing services at any time.

Medications Covered By This Agreement:

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_____ _____

Pharmacy **Address**

_____ _____

Patient Signature **Date**

_____ _____

Prescriber Signature **Date**

Violation:_____

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Date of Violation:_____**; Letter of Termination? YES/NO**