Patient Controlled Substance Contract

This Agreement is between _____(Patient)_____(DOB) and Advanced Practice Nursing Specialists. My provider has prescribed one or more medicines to treat my medical condition. These medicines are high risk and can be misused, abused, or lead to addiction. In order to comply with federal and state regulation, and for my safety, I agree to the following statements. I know that if I do not follow the statements below, my controlled substance prescriptions and/or treatment at APNS may be ended immediately.

1. ____ I know that controlled substances are one part of my treatment plan to help my condition and make my quality of life better. I know that controlled substances will not cure my condition. I understand that if my function does not improve while on these medications, the medicine may be discontinued or the dose lowered.

2. ____ I understand that in order to best treat my condition, it will require me to commit to a healthy lifestyle; including eating a healthy diet, staying as physically active as possible and managing my stress. I agree to work with my provider to achieve a healthy lifestyle.

3. ____I know that my treatment may change as my provider evaluates my progress or more medical information is available. If my provider feels I need to see a specialist, I agree to get a consultation.

4. ____I know that if I stop the medication suddenly, I may have severe withdrawal symptoms. If so, I will seek immediate medical attention at the nearest emergency room.

5. ____**I am responsible for my controlled substance medications.** I understand that sharing, selling, or trading my medication is illegal and is a felony. If the paper prescription and/or medication is lost, misplaced, or stolen, or if I use it up too soon, I know that the medication **will not be replaced.**

6. ____I agree to bring in my medications for pill counts at the request of my provider. I agree to unscheduled random urine or serum drug screenings at the request of my provider to ensure my medication is being used as prescribed. Failure to complete such a screening within 24 hours will result in a breach of this contract, and I will no longer be prescribed any controlled substances.

7. ____I will not ask for or take controlled substance medications from another provider or person. If I am given these medications by another provider or in a time of emergency, I will call the office the next business day to let my provider know.

8. ____Refills of controlled substances will only be given if I keep my scheduled appointment(s). I will call at least 3 business days ahead if I need a refill on the controlled substance medication(s) and know that refills will only be granted during regular business hours.

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9. ___I know that any controlled substance may interfere with or impair my ability to drive, perform intricate tasks and make important decisions. I understand that it is my responsibility to refrain from any activities that will endanger me or others while taking a controlled substance.

10. ____I will not use illegal drugs, including marijuana. If other drugs are found in my urine that are not prescribed or illegal, I will be referred for help with chemical dependency. I agree to follow through with any such programs deemed necessary by my provider. If I do not comply, I will be discharged as a patient.

11. ____I agree to use the office pharmacy of APNS for **ALL** my controlled substances. If I change my pharmacy for any reason, I agree to tell my provider.

12. ____For Females of child bearing age, I understand that taking controlled substances while pregnant is dangerous. Taking controlled substances during pregnancy can cause harm to the fetus and can lead to severe neonatal withdrawal after birth.

____I have read this contract.

____I understand this contract.

____All of my questions and concerns have been answered by my Nurse Practitioner to my satisfaction.

____I agree to all stipulations in this contract without reservations.

Patient's Signature _____ Date_____

Print Name_____

Provider's Signature_____ Date_____

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