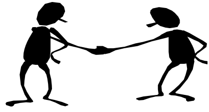
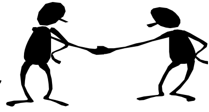


Controlled Substance Agreement



Dr. Stephanie Jones

I, ____, DOB____________________,
am receiving controlled substances to treat chronic pain and its associated conditions. ***The purpose of this agreement is to protect my access to controlled substances for the treatment of my pain.***

➢ *I understand the risks associated with opioid treatment, such as physical dependence, ADDICTION, change in personality, sleep changes, respiratory depression, nausea, constipation, bowel obstruction, changes in appetite, problems with coordination, decreased testosterone, sexual desire and death. While on controlled substances, I may have trouble operating a vehicle due to drowsiness and delayed reaction time. I must proceed with caution or STOP driving if I feel impaired at any time.* ***Stopping opioids suddenly can lead to rebound pain and to withdrawal symptoms, so I have been informed NOT to stop my opioid medication suddenly.***

➢ *To minimize risk and assure adequate supervision, I agree to come in for regular visits as determined by Dr. Jones. Failing to do so may result in a weaning dose of medications. . I agree to see any specialists deemed necessary.* ***I agree to have any labs you advise, including random drug blood levels and urine drug screens. I agree to come in on short notice for random pill counts to help assure I am taking my medications in the prescribed manner***

➢ *I agree to not change my dose without first discussing it with you, either by phone or in person. I understand that it is my responsibility to plan ahead and call in my prescriptions to the pharmacy or office (as necessary), 2-3 days ahead of time in order to give you ample time to authorize a refill for me. I agree not to destroy my opioid medication without first discussing it with you.* ***If my opioid medication is stolen, lost, destroyed or used up early, I understand that it may NOT BE REPLACED or REFILLED until the date of my next regular refill****.*

➢ *If I am having surgery of any kind, I will let you know ahead of time if possible. I will get my medications from only one pharmacy and will inform you of any change in my pharmacy. I will keep my medications in a safe, secure place to prevent theft, loss or accidental ingestion by other individuals (children).* ***I will NOT give or sell my opioid medication to anyone else to use, not even my family. I agree NOT to obtain any opioids from friends or other people. I agree NOT to obtain narcotics from any physician unless Dr. Jones is notified.***

➢ *Medication or drug interactions can increase the risk of taking opioids. I agree to keep Dr. Jones's office informed of any medication changes from any other doctor. I agree to inform you of my drinking practices so that we can discuss the risks of alcohol consumption. If I smoke cigarettes, I agree to discuss with you the desirability of quitting smoking.* ***I also agree not to use any illegal drugs, including Marijuana****.*

➢ *Also, due to the false positive of morphine/codeine that can occur with poppy seed consumption, I will not consume poppy seeds when on controlled substances so as not to interfere with my urine drug screen.*

➢ *I agree to make efforts to improve my functioning, and if I do not, I understand that my medications may be discontinued. I understand that medications are not filled after hours, weekends or holidays.*

➢ *I have been* ***HIGHLY*** *advised* ***Not to drive or operate heavy machinery while on narcotics.***

Patient: ______________________________/ Witness ______________________/Date:__ __________