CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

POTOMAC SQUARE FAMILY MEDICINE
13650 E. MISSISSIPPI AVENUE, SUITE 120
AURORA, CO 80012
303-695-8684

Controlled substance medications (i.e., narcotics, tranquilizers, and barbiturates) are very useful, but they have a high potential for misuse and are, therefore, closely controlled by the local, state, and federal government. They are intended to relieve pain to improve function and/or ability to work, not simply to feel good Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.________

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Potomac Square Family Medicine. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.________

3. Refills of controlled substance medication will be made only during Potomac Square Family Medicine's regular office hours, in person, once each month during a scheduled office visit. Refills will not be made at night, on holidays, or weekends, and will not be made if I "run out early," will not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will run out tomorrow. I will call at least twenty-four hours ahead if I need assistance with a controlled substance medication prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.________

4. I will bring in the containers of all medications prescribed by Potomac Square Family Medicine each time I am seen, even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.________

5. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Potomac Square Family Medicine might be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physician, medical facilities, and other authorities.________

6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, and the non-use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.________

7. I have been fully informed byPotomac Square Family Medicine, and its staff regarding psychological dependence (addiction) on a controlled substance, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and, when I stop the medication, I must do so slowly and under medical supervision or I might have withdrawal symptoms._______

8. I agree that I will obtain the following evaluations within forty-five (45) days of my initial visit. In order to have additional refills of my medications after this forty-five day (45) period, the office visit notes from these evaluations will be available for my chart here at Potomac Square Family Medicine. I also agree to obtain my past medical records and have them transferred to Potomac Square Family Medicine within (forty-five) 45 days. I also agree that my providers at Potomac Square Family Medicine will give strong consideration to any recommendations made by these specialists._______

   Specialist:___________________________________

   Specialist:___________________________________

8. The controlled substance(s) for which this contract applies are as follows:

   Medication:_____________________ Dose:___________

   Instructions:____

   Medication:_____________________ Dose:___________

   Instructions:____

I have read this contract and it has been explained to my by ____________________________ and/or his/her staff. In addition, I fully understand the consequences of violating said contract.

________________________________ ______________________

Patient Date

________________________________ ______________________

Witness Date