RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

ADULT CONTROLLED SUBSTANCE AGREEMENT

_____ _____
PATIENT NAME *DATE OF BIRTH*

_____ _____
PROVIDER *TODAY"S DATE*

Controlled substance medications are one part of the treatment for: _____
PRINT NAME OF CONDITION (e.g. ADHD, Anxiety)

The goals of this medicine are to help manage the signs/symptoms of my condition(s), stated above, as much as possible without causing dangerous side effects.

The patient must *initial* each statement after reviewing

_____ The patient's provider has completed medication counseling which includes the following information:

1. Controlled substances 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.
2. The patient should not drink alcohol or use drugs/substances while taking controlled substances.
3. Treatment with controlled substances may be discontinued or dose adjusted if medically necessary.
4. Chronic daily benzodiazepines (ativan, klonopin, xanax) can cause withdrawal if stopped immediately. Stimulants will not cause withdrawal if they are stopped.
5. I understand that controlled substances can be misused or abused, or lead to addiction.
6. Laws and regulations vary state-by-state, your provider may choose not to prescribe any controlled substances out of state electronically. Secure paper copies will be provided if appropriate

I understand, am responsible for and voluntarily agree that:

_____ I will schedule, keep, be on time for appointments before running out of my medication. Refills will only be provided at appointments. In extenuating circumstances I will call at least **5 business days** before I need a refill of my prescription. Refills will only be granted during my provider's regular business hours (your provider may not work every day of the week).

_____ I will not ask for or take controlled substance medications from another prescriber or person.If I am given these medications by another healthcare provider or in the time of emergency, I will inform my provider at River Valley behavioral health and wellness center the next 2 business days.

_____ I will participate in all other types of treatment as recommended. My treatment may change as my provider evaluates my progress or more medical information is available.

_____ The medication will be kept safe, secure, out of the reach of children and accessible only by myself. If the paper prescription and/or the medication is lost, misplaced, or stolen, or if I use it up too soon, the medication will not be replaced. I will bring in my medications for pill counts at the request of my provider.

_____ I will take the medication only as instructed and not change the way it is taken.

_____ The use of mood altering substances can negatively impact my response to treatment. I also understand that if my provider suspects drug use that could compromise my health, my medications will be discontinued, my provider may order a drug test, and/or my provider will refer me to an appropriate treatment program.

_____ I will sign a release of information form to allow the provider to speak to/release records from other healthcare providers as requested. I will inform the provider of all other medicines that I take, and let him/her know right away if I receive a prescription for a new medication.

_____ I will use only one pharmacy to fill the prescription (list below):

_____ _____
PHARMACY NAME & ADDRESS *PHONE NUMBER*

_____ I may be subject to random drug testing in the office or ordered outside of this clinic. Medications may ot be filled until results from tests are received.

_____ <u>For females of child bearing potential</u>: taking controlled substances while pregnant can be harmful to a fetus and can result in birth defects and or severe neonatal withdrawal after birth. I will immediately update my provider of any changes to my pregnancy status or if I am planning to become pregnant.

_____ In order to comply with federal and state regulations and for my safety, I agree to the above statements. I understand that if I do not follow the statements above, my controlled substance prescription and/or treatment at River Valley Behavioral Health & Wellness Center may be ended immediately.

_____ _____
PATIENT SIGNATURE *TODAY'S DATE*

_____ _____
PROVIDER SIGNATURE *TODAY'S DATE*