# Controlled Substance Agreement for Opioids

Patient Name: _____ Date of Birth: _____

Prescriber Name: _____ Today's Date: _____

This agreement puts us on the same page regarding your prescription, which is considered a controlled substance. Some special guidance applies to you and to us at WMC because your prescription is a controlled substance.

The long-term use of opioids (narcotic analgesics) has a potential risk to your health. Because of this, your provider needs you to read, understand, ask any questions, and agree to the following by signing your initials.

*Please initial on the lines below.*

## Terms and Potential for Harm

___ I am aware that the use of these medications has certain risks, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, and addiction.

_____ **Addiction** I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. It is much more common in a person who has a family or personal history of addiction. I agree to tell my medical provider my complete and honest personal drug history and that of my family to the best of my knowledge.

_____ **Tolerance** I am aware that tolerance to opioids means that I may require more medicine to get the same amount of pain relief. I understand that this may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my provider to choose another form of treatment.

____ **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical/sexual performance.

____ **(Females only)** If I plan to become pregnant or believe that I have become pregnant while taking this medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. Birth defects can occur whether or not the mother is on these medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

## WMC Partnership with You and Limits of Use

____ **Urine/blood/oral drug tests will be done at random times** as determined by my provider.

____ The state database (Prescription Drug Monitoring Program PDMP) will be checked every time the medication is prescribed.

____ I know opioid medications will not get rid of my pain completely, and the goal for treatment is to improve my day-to-day function. I know participating in activities I enjoy, daily physical activity such as walking, and other activities like deep breathing and mindfulness meditation can be as or more effective than opioid medication.

____ I agree that my provider team may require that a behavioral health provider, health coach, and/or physical therapist be part of my health care team. This is a sign of their care for me.

____ I agree to tell my provider of any changes to prescriptions, over-the-counter drugs, vitamins, and herbal medicines I am taking when requesting a refill. Marijuana and alcohol can impact your health, wellbeing, and pain. While these are legal, WMC will address recreational use on a case-by-case basis and document any additional agreements related to patient care on legal substance use while being prescribing an opioid.

____ I will no longer be prescribed controlled substances if I am arrested or put in jail related to legal or illegal drugs.

___ I agree to tell my provider within 48 hours if I have a drug overdose so they can best care for me. Naloxone prescriptions are available at WMC.

___ I will get rid of any unused opioid or controlled substances in a safe way, such as at Westminster Medical Clinic, a drop box at certain pharmacies, or police departments.

## Refills

____ Prescriptions will be written for **30 days** (up to 90 days for mail order only), or provider discretion between you and your prescribing provider. These prescriptions will have **no refills** provided without a visit.
*Please schedule your next refill appointment at the end of a visit.*
*Please call or message through the patient portal at least 3-5 days prior to needing a refill. This timeframe may be at the discretion of your provider.*

____ I will use my usual pharmacy for obtaining all prescriptions for my pain or other medical condition (unless medication shortages occur and a different pharmacy has the medication):

Pharmacy Name: _____Phone: _____

____ I will take my medicine as prescribed. I will not take more than my prescribed amount without receiving instructions from my provider.

____ I agree that my provider **team** will be the only ones prescribing controlled substances for me. In most cases, **a team provider** refills a prescription when the usual provider is not available. When a provider on the team refills a prescription for me, **the prescription will be for no more than 30 days**, regardless of the typical prescription amount with my usual provider.

____ I will not share my medication with anyone or sell them to anyone. This is a violation of federal law and will cause my provider to stop prescribing them to me and to notify the police. **I will not receive a refill for a lost, stolen, damaged, or spilled opioid prescription.**

____ I understand that if I abruptly stop my opioid or controlled substance that I may have withdrawal symptoms.

___ **I know any verbally or physically threatening abusive behavior toward providers or staff will lead to no further refills of my medication.**

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**By signing below, I agree that I have read and understood the above. Any questions I have about this agreement have been answered to my satisfaction. If I am not able to keep the promises made in this agreement, I will inform you. I understand that if I do not follow this agreement, my provider can choose to stop providing my medication treatment. If this occurs, I understand that the clinic will let me know this in person or at my last known address or phone number.**

**Patient/legally authorized signature: _____ Date: _____**

Prescribing Provider signature: _____ Date: _____

My Provider Team: _____