Health Center at AURARIA

Plaza Building, Suite 150 • Campus Box 20
P.O. Box 173362 • Denver, CO 80217-3362
Phone 303-615-9999 • **Fax** 720-778-5850 • **Web** healthcenter1.com

Controlled Substance Use Agreement

Legal Name (First name, middle initial and last name)	**Date of Birth**	**Today's Date**
	MONTH DAY YEAR	MONTH DAY YEAR

You have agreed to receive a controlled substance for the treatment of your condition. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. **Please read and initial each statement, then sign the agreement below**. If you have any questions regarding this information or the office policy regarding the prescribing of controlled substances, please request clarification.

____The goal of using a controlled substance is to treat or manage my condition and increase my functional level. If my medication(s) does not decrease my symptoms and/or increase my functional level, then my medication(s) can be stopped.

____I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: misuse, abuse, sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief of my symptoms.

____The overuse of my controlled medication(s) can result in serious health risks including respiratory depression or even death. My health care provider and the Health Center at Auraria are released from any and all liability due to adverse effects.

____Controlled medications are cataloged in a central pharmacy registry in the state of Colorado called the Prescription Drug Monitoring Program (PDMP). All prescribers at the Health Center at Auraria routinely review the PDMP at every visit when a controlled medication is prescribed.

____I am responsible for making and keeping scheduled appointments in order to receive prescriptions/ refills. Early refill requests will not be honored.

____I will take the controlled medication **only as prescribed**. Any changes **must** first be discussed and agreed upon with my health care provider.

____Medications **will not** be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen, and I complete a police report regarding the theft, an exception may be made. It is expected that I will take the highest possible degree of care with my medication and prescription. They should not be left where others might see or otherwise have access to them.

____I agree that only my HCA provider and/or my outside prescriber/specialist will prescribe my controlled medication. I will not obtain or use controlled substances from a sources other than my designated provider(s) (or a provider covering in their absence). I will instruct my other providers to confer with them for any changes or need for additional controlled medications.

____If I accept a prescription for a controlled substance from an outside provider — without discussing with my provider at HCA — while this agreement is in effect, it will be considered a breach of the agreement. The provider at HCA may respond as they feel appropriate, from ceasing to prescribe controlled substances to me, up to discharging me from the clinic.

____I will inform my Health Center at Auraria provider of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects that I may experience from any of the medications that I take.

____I will be completely honest in giving my full and accurate personal usage history of both prescription medications and non-prescription medications/drugs (including recreational or illicit use).

____I will not use any illegal "street drugs." I understand that combining or mixing controlled substances with other legal substances, including alcohol and/or marijuana, can cause interactions with the medication, can be harmful to my health (up to and including death) and can further impair my judgment.

____I will communicate fully and honestly about the character and intensity of my symptoms, the effect of my symptoms on my daily life, and how well the medicine is helping to relieve my symptoms.

____Routine blood work and random drug screens may be a part of my treatment plan. If a blood or urine sample is not provided, a prescription may not be provided.

____In order to ensure I receive appropriate care, I give permission for my HCA provider to discuss pertinent diagnostic and treatment details with dispensing pharmacists or other professionals who also provide health care to me.

____If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.

____It is a felony to obtain controlled medications under false pretense. This could include getting medication from more than one provider; misrepresenting myself to obtain medications; using the medications in a manner other than prescribed; or diverting the medications in any other way (eg, selling or giving to a friend or relative).

____I know that controlled medications may be discontinued if the clinic finds that I have broken any part of this agreement, including, but not limited to, the following:

- If I trade, sell, or misuse the medication
- If I do not provide a blood or urine sample when asked
- If my blood or urine test shows the presence of medications of which staff have not been made aware; the presence of illegal drugs; or does <u>not</u> show presence of expected, prescribed medications
- If I get controlled medications from sources other than my designated providers and do not inform my HCA provider
- If I repeatedly reschedule, or consistently miss, scheduled appointments

By signing below I affirm that I have read, understand and accept all of the terms of this agreement.

Patient Signature	**Date**
	MONTH DAY YEAR