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

This document describes the risks and responsibilities associated with receiving treatment with a controlled substance through the Health Center at Auraria. Please read each statement below carefully and write your initials in the space provided for each item to indicate that you understand and agree. Patients must read, initial, and sign the controlled substance agreement to receive prescriptions for stimulants and other controlled medications from the Health Center at Auraria.

Purpose of Treatment

☑ I understand that the goal of using stimulants or other controlled medications is to manage my condition and improve my functional level. If the medication does not achieve these goals, it may be discontinued.

Risks of Controlled Substance Use

___ I understand controlled medications carry risks including, but not limited to: nervousness, headache, nausea, appetite changes, insomnia, drowsiness, sexual dysfunction, dizziness, confusion, dry mouth, elevated heart rate or blood pressure, tolerance, dependence, withdrawal, addiction, and—in rare cases—seizure, stroke, heart attack, or death.

___ I understand that overuse or misuse of controlled substances can result in serious health consequences including death.

Safe and Appropriate Use

___ I will take my medication exactly as prescribed and will not adjust the dose or how the medication is taken without provider approval.

___ I will not use illegal substances and understand that combining my medication with alcohol, marijuana, or illegal or unapproved substances may be harmful and can cause serious health complications.

___ I will provide full and honest information about my symptoms, response to medication, and substance use, including the use of prescription medications, non-prescription medications, drugs, and alcohol.

___ I will notify my provider about any changes to my health, medications, or adverse effects I experience.

Monitoring and Accountability

___ I agree to provide urine or blood samples as requested. Refusal to provide a sample when requested may result in discontinuation of medication.

___ I understand that abnormal test results, such as the presence of non-disclosed substances, may prompt discontinuation of medication.

___ I understand that controlled medications are cataloged in a central pharmacy registry through what is called the Prescription Drug Monitoring Program (PDMP). Pharmacists and all prescribers at the Health Center at Auraria will review this resource regularly to ensure controlled medications are being prescribed and filled appropriately.

Prescribing Limitations

___ I agree that only my HCA provider (and/or an authorized specialist) will prescribe my controlled medications.

___ I will not accept controlled substance prescriptions from other providers without notifying HCA in advance, except in cases of emergency care.

Medication Security and Replacement

☐ I will protect my medication and prescription from loss, theft, or misuse. Requests for replacement prescriptions will be evaluated on an individual basis and may or may not be provided at the discretion of the prescribing provider.

Legal Standards

☐ I understand that it is illegal to obtain medication under false pretense, whether by presenting false information or deliberately omitting pertinent information, such as receiving controlled substances or other treatment provided by other health care providers. Medication provided to you is intended specifically for your use and cannot be given to, shared with, or sold to others. Providing your controlled substance medication to others is called diversion. Diversion is illegal and can lead to serious legal consequences.

Appointments and Refills

☐ I understand I must be seen at an appointment at least every 6 months—or less, at the discretion of the prescribing provider—to continue receiving treatment with controlled medications. Failure to be seen for appointments with the frequency expected may preclude the provision of refills or additional prescriptions for controlled substances.

Confidentiality and Care Coordination

☐ I give permission to my provider to share pertinent diagnostic and treatment information with pharmacies and other health care providers involved in my care.

☐ I understand that confidentiality may be waived if legal authorities require information about my treatment with controlled medication.

Agreement Violation

☐ I understand that violating any part of this agreement may result in termination of treatment with controlled medications. Violations include:

- Misuse, abuse, or diversion
- Refusal to submit a blood or urine sample for drug testing
- Use of illegal or unapproved substances
- Receiving prescriptions from unauthorized providers
- Failure to attend appointments regularly

Acknowledgment

By signing below, I confirm that I have read, understood, and agree to comply with all terms and responsibilities outlined in this agreement.

Patient Name (Printed)	Patient Signature	Date MONTH DAY YEAR

Witness Name (Printed)	Witness Signature	Date MONTH DAY YEAR