KANIKSU COMMUNITY HEALTH

WHOLE HEALTH FOR YOUR WHOLE LIFE

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Controlled Substance Policy

The purpose of this Agreement is to prevent misunderstandings about certain controlled medicines (narcotic pain medications, stimulants, anti-anxiety medications etc.) that your provider will prescribe for you. This is to help both you and your care provider comply with the law regarding controlled pharmaceuticals.

I _____ (print name), authorize the information in this agreement to be shared with other medical providers, clinics, pharmacies, hospitals, DEA and Law enforcement agencies including the State Pharmacy Board as deemed appropriate by my health care provider.

_____ I agree that I may receive additional controlled medications in emergency situations (acute injury, post surgery etc.) but I agree to notify the prescribing provider that I am on a Controlled Medication Agreement and will reveal all controlled substances (and doses) that I am taking. I also agree to notify my provider within 48 hours that I have received additional medications and all information pertaining to those medications (reason for prescription, dose, frequency of dosing, number prescribed, etc.)

_____ I agree to use only one pharmacy to fill my controlled medicines.
I have chosen: _____

_____ I agree to use only one provider to prescribe my chronic controlled medications. That provider has signed below.

_____ I agree to make no more than one request per day for refills.

_____ I agree that refill requests may take up to 72 hours to process and will time my requests accordingly.

_____ I agree that refills will be made only during regular office hours. Refills will not be available evenings, weekends or holidays.

_____ I agree that lost or stolen medications will not be replaced. I agree to use my medicines only at the rate prescribed by my provider. If the prescribed dose or rate is not adequate, I will notify my provider immediately.

_____ I agree to submit to urine and/or blood tests if requested by my provider to determine my compliance with my chronic controlled medication program. If asked, I will bring in my medication for a medication count.

_____ I agree that if I violate this agreement, my provider may stop prescribing these controlled medications. A short tapering dose may be allowed and a referral to a Chemical Dependency Treatment Program may be made.

Things that may constitute violations of this agreement are as follows:

- Using illegal substances (cocaine, “crystal meth", non prescribed marijuana, heroin, etc.)
- Sharing, trading or selling my prescribed medications.
- Failing to take medicines as prescribed by my health care provider.
- Taking controlled medications not prescribed to me by my provider,
- Failing to submit to a urine or blood test to check for controlled substances or illegal substances.
- Failing to bring in my controlled medications when asked by your provider for a "med count".
- Overdosing on my controlled medications or an illegal/non prescribed substance.

- Attempting to obtain controlled substances from providers or pharmacies outside of those listed in this agreement (except in emergency situations listed above).
- Harassment/abuse of clinic staff either physical or verbal.
- Abuse of alcohol.

_____ I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement will be in effect until revoked in writing by myself and acknowledged by my provider.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Witness Signature: _____ Date: _____