Coastal Medical
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Coastal Medical
Controlled Substance Agreement

Name _____ DOB____/____/____

Provider _____

Medication:_____Strength_____

Direction: _____

Medication:_____Strength_____

Direction: _____

Condition Treated:_____

Desired Functional Outcome_____

Date of Next Assessment:_____

Coastal Medical is committed to provide the best care for our patients with chronic pain conditions, anxiety, and attention deficit hyperactivity disorder (ADHD), which can impact patients' everyday lives. While doing so, controlled substances can be used as a therapeutic option to relieve patients' symptoms. Controlled substances include, but are not limited to, opioids (hydromorphone, morphine, oxycodone, fentanyl, etc), stimulants (amphetamine, dexmethylphenidate, methylphenidate, etc), and benzodiazepines (alprazolam, lorazapam, clonazepam, etc). This agreement is to improve functional therapy outcomes, reduce risk for adverse events, and ensure proper use of controlled substances within both state and federal laws. The word "I", "me", or "my" refer to the patient.

I. Impact of Controlled Substances

I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function, which may affect mood, stamina, sexual desire, and physical and sexual performance. Treatment with opioid therapy can also suppress breathing, which may lead to death in some circumstances. This risk is increased if I take opioid medication in a manner other than how it is prescribed by my provider (overdose) or if I take them in conjunction with alcohol, other medications (eg. Benzodiazepines) or illegal drugs.

Narcan (naloxone) is an agent that can reverse opioid overdose and is available without a prescription at any Walgreens Pharmacy in the state.

Long-term and/or high doses of pain medications may cause increased levels of pain known as opioid-induced hyperalgesia (Pain medicine causing more pain). I understand that opioid-induced hyperalgesia is a risk of using pain medications for a long period of time or at high doses. Treatment of opioid-induced hyperalgesia may require reducing or discontinuing of the current opioid medicine, rotating to other opioids, or adding medications such as Advil.

For female patients: I understand that taking opioid medications during pregnancy will cause the baby to be physically dependent to opioids. Maternal opioid intake during pregnancy may also cause birth defects although it is extremely rare. I will immediately call my obstetrician and Coastal Medical to inform of my pregnancy.

Benzodiazepines also carry the risk of addiction and abuse, as well as somnolence, incoordination and respiratory depression. These risks are additive when used in combination with opioids and alcohol.

Amphetamines also have the risk of addiction and abuse, as well as cardiovascular risks including increased heart rate and increased blood pressure, aggressive behavior, psychotic disorders, decreased growth and weight loss.

II. Physical Dependence and Tolerance

I understand that physical dependence is not the same as addiction. Physical dependence means that I will experience a withdrawal symptom if my medicine use is markedly decreased, discontinued, or reversed by other drugs. Withdrawal symptoms from opioids include runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. Withdrawal from benzodiazepines includes hallucinations and confusion, grand mal seizures, restlessness, sleep disturbances, dizziness, apprehension, tremor, abdominal and muscle cramps, nausea, vomiting, dysphoria, sweating, and headache. Withdrawal from stimulants includes extreme fatigue, mental depression and changes in sleep.

I understand that tolerance to analgesia means that I may need more medicine to get the same amount of pain relief. If I become tolerant to opioids, increases in dose will not provide adequate pain relief and may cause more side effects. Tolerance or failure to respond well to opioids may lead to different form of treatment, reduction of the dose, or discontinuation of opioid therapy.

III. Obtaining Prescriptions

I understand that controlled substances are high risk medications that require routine monitoring. I understand the office policy is that I am seen by my provider a minimum

of two visits per year. Cancelling or not showing up for visits is grounds for termination of controlled substance prescribing.

I understand that all controlled substances must come from the designated provider whose signature appears in the last page, unless specific authorization is obtained for an exception. Any exceptions will be documented in my record and will require me notifying the designated provider PRIOR to obtaining controlled substances.

I understand that I must inform the designated provider or his/her covering provider of all of the medications that I am taking, have purchased, or have obtained including over-the-counter medications. Failure to do so may result in drug interactions or overdoses that can result in harm to me. I will also bring all of my controlled substance prescription bottles to every visit with all unused medicine.

I understand that I will not seek prescriptions for controlled substances from any other physician, healthcare provider, emergency room, walk-in clinic, and/or dentist. I understand that it is unlawful to be prescribed multiple controlled substances by more than one provider without each provider's knowledge.

I understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a provider or his/her staff or knowingly withholding facts from a provider or his/her staff. I will inform the provider or his/her staff of all controlled substances that I have been prescribed.

I understand that the designated provider will utilize the Rhode Island Department of Health Prescription Monitoring Program to monitor my controlled substance filling activity at any pharmacy in the region processed through insurance and cash pay. Evidence of unauthorized prescription fills will result in termination of controlled substance prescribing. I understand that the provider or his/her staff will call pharmacies to verify controlled substance filling activity in addition to checking the Rhode Island Department of Health Prescription Monitoring Program.

IV. Filling the Prescriptions

All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed.

The pharmacy that I have selected is:

Pharmacy:_____

Phone:_____

V. Controlled Substance Management

I understand that I must not share, sell, or permit others, including my spouse or family members, to have access to any controlled substances that I have been prescribed. Storing controlled substances in a locked box is recommended, as replacements will not be issued for lost or damaged medications. Lost and damaged medications include medications that are wet from water or other liquids and medications that I misplaced.

Stolen controlled substances will not be replaced unless explicit proof is provided with direct evidence from authorities such as police report. I understand that a report narrating what I told the authorities is not enough.

VI. Refills and Medication Change

I understand that refills for my controlled substances will be made only at the times of an office visit or during regular office hours. Refills will not be available during evening hours or on weekends. I will show my state issued photo identification every time I pick up my prescriptions. I understand that I can authorize a person (s) to pick up prescriptions on my behalf. Only those whose names appear below will be allowed to pick up prescriptions for me. The designated person(s) will show their state issued photo identification. Any changes to this list must be made by me in writing.

I understand that requests to mail prescriptions to my home will not be accommodated.

I understand that if I lose my prescription it will not be replaced.

I will follow prescribed directions and I will not consume excessive amounts of controlled substances.

I understand that medication changes will not be made between appointments. I will call the office to schedule a next available appointment to allow the designated provider to determine if medication changes are needed.

The following individual(s) may pick up prescriptions for me:

Name:_____

Address:_____

Name:_____

Address:_____

VII. Use of Other Substances

I will cooperate with the request for unannounced pill counts, random urine or serum (blood) screening, or planned drug screening. I will present to the lab within 24 hours of being contacted or be discontinued from controlled substance prescriptions. I understand that the presence of unauthorized substances in my urine or serum (blood) toxicology screens will result in discharge from treatment by Coastal Medical and my provider and staff. Unauthorized substances include any illegal substances such as marijuana, cocaine, or heroin in addition to any controlled substances that were not prescribed by the designated provider.

I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any illegal drugs such as marijuana, heroin, and cocaine.

I understand that driving under the influence of any substances, including prescribed controlled substance or any combination of substance (alcohol and prescription drugs) may impair my driving ability and result in DUI charges.

VIII. Privacy

I understand that the prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists, other professionals engaged in your healthcare, or appropriate drug and law enforcement agencies.

I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of it terms. A copy of this document has been given to me.

Patient's Full Name	Date
Patient's Signature	Date
Provider's Signature	Date
Witness's Signature	Date

_____ Patient initials indicating information has been reviewed