CONTROLLED SUBSTANCE AGREEMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICE CENTERS
SFN 736 (11-2016)

Patient Name	Client ID Number

While there are numerous treatments for your condition, one or more of the medications you and your psychiatric prescriber (provider) have discussed as an appropriate option is called a "controlled substance". In addition to benefits, these medications can pose potential risks to both individuals and society. Potential risks to individuals include substance use related problems (addiction), overdose and even death. Potential risks to society include, among others, diversion (giving/selling) of these medications to someone else. Therefore, they are regulated by the government and prescribed with caution. Certain controlled substances are recommended for short term use only. Others may be prescribed for a longer period. This is determined based on your condition, medical history, as well as the particular medication prescribed.

The purpose of this agreement is to reflect our mutual commitment to safe use of these medications. Not adhering to this protocol may result in termination of this agreement and discontinuation of these medications. This form does not take the place of informed consent regarding the specific medication you are being prescribed.

Initial each section to indicate your agreement and understanding. Please ask for any clarification if needed.

_____ I have informed my provider of any past history of substance use disorders or problems. Because medications and other drugs may have unsafe interactions, I will inform my provider of any other medications or drugs I am taking - both legal and illegal. This also includes over-the- counter medications or supplements. I understand that a urine drug screen may be requested of me at any time during my treatment. If my provider feels it is indicated, I will agree to have a chemical dependency evaluation in order to help determine the best course of treatment.

_____ I understand that the safe keeping of this controlled substance is my responsibility. It will be kept in a safe and secure area. I understand that lost, stolen, or damaged controlled substances will not be replaced before their scheduled refill, unless an extremely rare exception applies.

_____ I agree to take the medication only as prescribed. I will NOT make adjustments to dosages without prior approval from my provider.

_____I agree that the condition for which I am being treated will be managed only by this provider while I am a client of the facility. Concerns from other health care providers are to be directed to my provider at this facility. If I am treated with the same or similar medication during an emergency or urgent medical visit elsewhere, I will immediately inform this facility.

_____ I understand that I am responsible for making sure I do not run out of my medication (including weekends or holidays) and will call the pharmacy (or this facility if appropriate) at least a day before my medications need to be refilled.

_____ If requested, I agree to bring my prescription bottles to my appointments and that the contents may be counted by medical staff if warranted.

_____ I understand that my provider may contact other healthcare providers or pharmacies, including the Board of Pharmacy, to review my medication and treatment history. I also understand that this facility participates in the ND Prescription Drug Monitoring Program. (This is a program that collects prescription data on controlled substances).

_____ I agree that, if requested, I will enroll in a monitored medication program for closer oversight of medication quantities.

_____ I understand that other evaluations and treatments may be recommended before or during the prescribing of controlled substances, depending on my condition. This could include evaluations for attention deficit hyperactivity disorder and cognitive-behavioral therapy for anxiety.

_____I understand that if indicated, my provider has the right to stop prescribing controlled substances. Depending on the circumstance, this could be a gradual taper or abrupt discontinuation of medication. If so, and I receive my medication at this facility, for safety reasons I might not be allowed to take possession of the remainder of the supply, even if I have paid for it. I understand that my provider has an obligation to provide me with recommendations for minimizing risks due to withdrawal.

_____ I understand that there may be symptoms of withdrawal associated with abrupt discontinuation of controlled substances. Withdrawal symptoms can vary from mild to life threatening, depending on the medication, length of treatment and medical conditions. I also understand that altering my dose without permission may result in going without medication which may place me at risk for withdrawal. Withdrawal management may require additional care at a medical facility.

_____ I understand that misuse, selling, diversion, or any other inappropriate use of this medication may result in termination of this contract or care at this center, or both. I understand that altering a prescription in any way is against the law, as is forging or fabricating a prescription. I understand that this facility cooperates fully with law enforcement agencies, as permitted or required by law, in regard to infractions involving prescription medications.

_____ I understand that abusive, violent or threatening behavior towards staff or other patients is not acceptable and may result in termination of this contract or care at this center, or both.

Patient Signature		Date
Provider Signature	Name of Facility	Date