

Patient Name

DOB:

MR #

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
CONTROLLED SUBSTANCES MEDICATION
AGREEMENT

Index to Medication Agreement

Date: _____

I understand that _____ agrees to prescribe *controlled medications* (opioid medications or others) to help me manage _____. I understand that I must follow all of the following conditions to receive treatment with controlled medications, and I understand that controlled medications may be safely stopped if I cannot follow these conditions.

1. Controlled medications are intended to help me function better. If my function or activity level gets worse, my provider will change or stop the medication.
2. Controlled medications are only a part of my treatment. I will take part in other treatments that my provider recommends. These may include physical therapy, exercise, psychological care, and others.
3. At every visit, I will talk honestly and fully to my provider and care team about my health, function, goals, medication use, and medication side effects.
4. To make sure my treatment plan is working, I will allow my provider to discuss my care with other providers or pharmacists involved in my care. I will authorize the release of information where needed. My provider will use state prescription databases to check on my controlled medication treatment.
5. My provider has explained the risks of using alcohol, illegal drugs and illicitly obtained prescription medications while taking my prescribed controlled medications, and I understand those risks. I will follow my provider's rules about alcohol and illegal drug use and the use of unauthorized prescription medications. To keep me safe, I will tell my provider about any past or current problems with alcohol or drug misuse or addiction.
6. I will keep all scheduled appointments with my provider. I will attend my appointments on time. If I cannot attend an appointment, I will call to reschedule it at least a day in advance so that others may use the time. If I miss or reschedule a number of appointments, my provider may elect to stop prescribing controlled medications.
7. I will take my medications exactly as prescribed. I will not change the medication dose or schedule without my provider's permission.
8. I will get my controlled medications from one pharmacy: _____
9. Only my provider, or his/her delegates, may prescribe controlled medications to treat my pain condition.
10. If I need dental work or surgery, I will tell those providers that I am receiving controlled medications so they can work safely with me and my provider to make sure my pain is managed.
11. I may use the Emergency Department or Urgent Care to treat an emergency medical condition. I will tell emergency or urgent care providers that I am prescribed controlled medications, and will give them my prescribing provider's name and phone number. Emergency or urgent care providers are allowed to treat pain related to an acute emergency medical condition. I understand that the Emergency Department or Urgent Care may not treat acute worsening of chronic pain with opioid or other controlled medications. I may not use emergency or urgent care visits to get additional controlled medication for my chronic pain. If I do, my provider may decide to stop prescribing controlled medications.
12. I am responsible for making sure my prescriptions are filled on time. I will follow my provider's rules for requesting and refilling controlled medications. I will provide at least 3 business days' advance notice that I need a refill so that I do not run out of medicine. Refills will not be given on an emergency basis. Refills will only take place during normal business hours.
13. I understand that my provider will not give my written prescriptions for controlled medication to anyone but me unless I sign a release allowing someone else to pick them up. Any person will be asked to show identification before picking up any prescriptions.
14. I will not ask for early refills. I understand that lost or stolen prescriptions will not be replaced. I am responsible for and will keep my controlled medications in a safe and secure place, such as a locked cabinet or safe. My provider has told me about the danger these medications may have if taken by others. I will immediately report stolen medications to my provider and to the police. This report does not mean that my stolen medication(s) will be replaced.
15. I will not give or sell my medications to any other person. I will not change or forge written prescriptions. If I do these things, my provider will stop my controlled medications and may end the provider-patient relationship.
16. I will let my provider know about all of the medications I am taking, including over-the-counter medications, vitamins and supplements. I will tell my provider if there are any changes in my medications, including those prescribed by other providers (for example, in case I am in the hospital or have surgery).

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- 17. If I have side effects such as dizziness, drowsiness or changes in thinking, I will avoid driving or operating heavy machinery, and I will contact my provider for advice. I will check with my provider before starting to use other medications that might increase my risk of these sideeffects.
- 18. I authorize my provider to order counts of my controlled medications to check that I am taking them properly. I agree to bring in my medications in their original containers to be counted.
- 19. I authorize my provider to order urine drug testing to make sure I am using my medications correctly. I will provide urine samples for testing when asked. If I do not give a sample, or if unexpected drugs are found in my urine, or expected medications are not found in my urine, I understand that my provider may decide to stop controlled medications or even end the provider-patient relationship. I understand that my insurance or myself will be responsible for any related costs.
- 20. I understand that all clinic staff members are important to the success of my treatment. I will treat them respectfully at all times.
- 21. If controlled medications are not helping me, if I cannot follow the terms of this agreement, or if I no longer need treatment with controlled medications, my provider will help me to safely decrease and stop the medications. My provider will make the final decision.

My provider has explained the risks, benefits, side effects and alternative treatment options for controlled medication treatment, including the risk of addiction, and I understand them. I have had an opportunity to ask questions about controlled medication treatment.

I have read and understand this document and agree to all of the above conditions of controlled medication treatment. This agreement will not go into effect until my provider and I have signed it.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is:
- Minor
 - Incompetent / Incapacitated
- Legal Authority:
- Legal Guardian
 - Parent of Minor
 - Health Care Agent
 - Other _____

Physician Signature: _____ Print Physician Name: _____

Date: _____ Time: _____ Pager# _____

Interpreter or Reader Signature (if applicable) _____

Witness Signature* _____

Print Interpreter or Reader Name _____

Print Witness Name _____

Date _____ Time _____

Date _____ Time _____

* Only required if patient signature not obtained by physician or when telephone consent obtained.