Woodrome Medical, PA
Patient Controlled Substance Agreement

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the controlled substance treatments we use. In this regard, we may refer you to a Pain Management program to ensure you have access to the best, safest treatments available. If your controlled substance medication (pain, stimulant, sedative) requires ongoing prescriptions that have significant addiction potential we will be requesting you to see a s specialist as applicable. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.

I, _____understand that I am being prescribed ,_____ which is a controlled substance; therefore I must adhere to the following restrictions.
Failure to conform to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.

1. I will not use alcohol/illegal drugs while being prescribed medication(s).

2. I will not take any other prescribed medications without first notifying my doctor.

3. I will notify my doctor immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including emergency rooms and immediate care center). Legally, failure to do so is a crime (obtaining or attempting to obtain drugs by fraud and/or deceit) and may be reported to the Police.

4. I will submit to random urine and/or serum drug screens as ordered.

5. I will only fill prescriptions for controlled substance at the pharmacy listed below. I will inform my doctor of any plans to change pharmacy. I will not obtain controlled substances from more than one pharmacy at a time. The only exception will be for acute need outside of the local area. I will authorize my doctor to communicate with my pharmacist.

Pharmacy: _____Phone:_____
Address/Location:_____

6. I authorize my doctor to communicate with all physicians I have seen.

7. I understand it is illegal to share this medication.

8. I agree to keep my medication safe and secure in order to prevent loss or theft.

9. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.

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10. I understand that some of these medications may cause drowsiness and slower reflexes, interfering with the ability to drive and operate machinery, and short-term memory impairment. I understand that overdose of this medication may cause death.

11. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.

12. I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications. I understand and accept the risk of addiction that can occur with this medication.

13. I authorize this office to release a copy (or original) of this controlled substance agreement to the Police if I violate any of the listed terms or at their request.

14. (Y or N) Have you received ***any*** prescription medications from ***any*** other physician in the past thirty days? If yes, please list physician and medication below.

Physician:_____ Phone Number _____
Medication(s):_____

15. I understand I may be called at any time to the office for a count of all my remaining medications. I agree to arrive on the day notified and will be **responsible for any costs this may incur.**

16. I waive my right of privacy and authorize my doctor to contact any health care provider, legal authority, friend and/or relative in order to obtain or provide information about my care (including abuse of controlled substances).

17. **No refills will be authorized on weekends, holidays or after office hours**. An exception may be made at the doctor's discretion if you are seen for an office visit with a copy of a completed police report.

18.Only the person for whom the *official* (previously known as triplicate) is written may retrieve the prescription, In the event that the patient is unavailable please list designee below.
Designee will be required to show picture identification._____
I read the above, asked questions and understand this agreement. If I violate this agreement, I know the physician may discontinue my treatment.

_____	_____
Patient Name (PRINTED)	**Date of Birth**
_____	_____
Patient / Legal Guardian	**Signature Date**
_____	_____
Physician Signature	**Date**