Ocala Oncology
FLORIDA CANCER AFFILIATES
The US Oncology Network

Agreement for Controlled Substances Prescriptions

Patient's Name: _____ DOB: _____

Controlled substance medications (i.e. pain, anti-anxiety, and stimulant medications) are very useful, but have a high potential for misuse and are therefore closely controlled by the federal, state, and local government. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my physician is prescribing such a medication for me to help manage my symptoms, I agree to the following conditions. Please initial each number when read.

1. _____ I am responsible for my controlled substance medication.
    a) If the prescription of medication is lost, misplaced, stolen, of if I use it sooner than prescribed, then I understand it cannot be replaced.
    b) I will use my medicine at a rate no greater than the prescribed rate and understand that use of my medicine at a greater rate will result in my being without medication for a period of time.
    c) If rate of medicine prescribed is not relieving pain, I will contact physician's office to let the doctor/nurse know so the dosage can be adjusted and noted in record.
    d) I will not share, sell, or trade my medication with anyone.
2. _____ I will not request or accept controlled substance medications from any other physician while I am receiving the same medication from my physician, as this may endanger my health. The only exception is when it is prescribed when I am admitted to the hospital.
3. _____ Refills of controlled substance medication:
    a) Will be made only during regular business hours between the hours of 8am ad 5pm, Monday-Thursday and between 8am and 12pm on Friday once each month or during a scheduled office visit. Refills will not be made after business hours (i.e., at night, on holidays, or weekends).
    b) Will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c) Will not be made as an "emergency", such as a Friday afternoon, because I "suddenly realized I will run out tomorrow". I will notify the clinic staff at least 5-7 days in advance if I need assistance with a controlled substance medication prescription.
4. _____ While I am receiving controlled substance medication, it may be deemed necessary by my doctor for me to see a specialist in interventional pain, psychology, psychiatry, or other specialty with the goal of improving my symptoms. I understand if I do not attend this appointment that my medications may not be continued or refilled past a tapering dose to completion. I understand that if a specialist feels that I am at risk for psychological dependence (addiction) that my medications no longer will be refilled.
5. _____ I understand that driving a vehicle may not be allowed at times while taking controlled substance medications, and that it is my responsibility to comply with the laws of this state while taking the controlled substance medication prescribed.
6. _____ I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment may be tapered immediately. If the violations involve the use of non-prescribed, illicit (illegal) drugs while I am receiving my controlled substance medication or involves obtaining controlled substances from another individual as described in section 2, then I may also be reported to my physician, medical facilities, and other appropriate agencies.

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7. _____ I understand that the main treatment goal is to improve my ability to function, and/or work, and/or reduce pain. In consideration of that goal and the fact that I am given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

8. _____ I understand that the long-term advantages of chronic opioid use have yet to be scientifically determined and treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance medications and that my physician will advise me as knowledge and training advances will make appropriate treatment changes.

I have been fully informed regarding psychological dependence (addiction) of a controlled substance medication, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of medication to achieve the desired effect. I also understand that I can become physically dependent on the medication if I am on the medication for several weeks, and that in order to stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this agreement and I understand the consequences of violating this agreement. If I have any questions, then I can ask the physician or staff regarding the use of controlled substances at any time.

I agree to use _____ Pharmacy, located at _____, or in case of an emergency

I agree to use _____ Pharmacy, located at _____, for filling prescriptions for all of my controlled substance prescriptions.

_____ _____
Patient/Responsible Party Signature *Date*

_____ _____
Witness *Date*