personal primarycare
& WEIGHT MANAGEMENT

299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Controlled Substance Contract

Name ____

Address ____

Date ______________________

I have tried other medical treatments, which have not worked to control my condition. My primary care physician or prescribing physician, ______________________ has recommended that I be placed on a trial of a controlled substance, as defined by Massachusetts General Laws, Chapter 94C, Section 1, to help manage my condition better and to improve my ability to participate in social and work activities. This is a decision that I have made after fully discussing with my primary care physician or prescribing physician the risk and benefits of this treatment, as well as alternative to this treatment.

RISKS

I understand that treatment of my condition with controlled substances does have risks; including, but not limited to:

- Constipation
- Nausea
- Sleepiness or drowsiness
- Problems with coordination or balance that may make it unsafe to operate equipment or motor vehicles
- Confusion or other change in mental state or thinking abilities
- Physical dependence (addiction)- which means that abrupt stopping of the drug may lead to a withdrawal syndrome characterized by one or more of the following:
  - Runny nose
  - Diarrhea
  - Abdominal cramping
  - "Goose flesh"
  - Anxiety
- Psychological dependence (addiction) - which means it is possible that stopping the drug will cause me to miss or crave it.
- Decreased appetite
- Problems urinating
- Breathing too slowly - Overdose can lead to respiratory arrest and death
- Sexual difficulties
- Known and unknown risks to unborn children, which include controlled substance dependence
- Other - less common risks and side effects are possible

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Conditions

My physician is willing to begin or continue treating me with controlled substances as other acceptable forms of medical treatment have not been effective or have produced too many side effects.

I agree to the following:

1. I do not currently have problems with substance abuse or dependence. I will inform my provider of any history of drug abuse or addiction.
2. I am not currently involved in and will not become involved in the sales, illegal possession, diversion, or transport of controlled or illegal substances (narcotics, sleeping pills, nerve pills, painkillers, cocaine, marijuana, etc).
3. I agree to notify my primary care physician or prescribing physician of controlled substance prescriptions from outside providers.
4. I will seek medical attention for any additional acute pain problems (i.e. toothache, abdominal pain, etc) and not take more of my controlled substance pain medication than prescribed.
5. I will NOT use my controlled substance medication as an emotional crutch (i.e. to get me through a stressful day, etc).
6. I understand that controlled substance medications are to be used only for the condition that they were prescribed. Increase in dosages will only be authorized in consultation with my physician.
7. I will use only {PHARMACIES:24158} Pharmacy for filling of prescriptions for these controlled substances.
8. I agree to call for my prescription refills between 8:30-4:30 Monday through Friday. Medications will be prescribed in amounts to ensure that refills will occur during weekdays.
9. Early refill requests will not routinely be issued to accommodate out of town travel.
10. I understand that controlled substance prescriptions can be picked up by myself or a designated delegate. A photo ID and signature will be required for pick up by myself or designated delegate.
11. I will take medicines only as prescribed by my primary care physician, prescribing physician and/or his colleagues and under no circumstances allow other individuals to take my medication.
12. I give permission to my primary care physician, prescribing physician and/or his colleagues to communicate with any other physician or health care provider and any pharmacists regarding my use of controlled substances.
13. I will follow the advice of my primary care physician, prescribing physician and/or his colleagues in regard to stopping my use of controlled substances, should they feel it advisable.
14. I understand and consent to unannounced blood screens, urine tests and pill counts (medication must be kept in their original bottles) in order to assess properly the effects of the controlled substances I am taking and to assess my compliance with my medical regimen. Failure to comply with a request for urine drug screen or pill count within 24 hours will be considered a violation and may result in termination of controlled substances.
15. I understand that my primary care physician or prescribing physician may recommend health care consultations with and evaluations by the following providers, and I agree to participate, if recommended:
    a. I will see a psychiatrist for evaluation for psychiatric medications and treatment.
    b. I will see a psychologist or other health care provider for behavioral or other mental health care therapies, which may include Behavioral Pain Management.
    c. I will see a physician or other health care provider for other medical conditions.

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16. Due to known and unknown risks to unborn children, which include controlled substance dependence, I will notify my primary care physician if I am pregnant, plan to become pregnant or if I become pregnant in the future.
17. I understand that allowances will not be made for lost, stolen or misplaced prescription or drugs. Any stolen prescription must be reported to the police and my provider immediately. A police report must be presented. Lost prescriptions must be reported to my provider within 24 hours.
18. I understand that my controlled substance treatment may be stopped at the discretion of my provider at Personal Primary Care & Weight Management if any of the following occur.
    a. My primary care physician, prescribing physician and/or his colleagues' feel that controlled substances are not effective for my condition or that my functional activity is not improved.
    b. I distribute the drugs to others or misuse the drugs.
    c. I develop a tolerance for or loss of effect from this treatment.
    d. I develop side effects that my primary care physician, prescribing physician or his colleagues believe are significant and detrimental to me.
    e. I obtain controlled substances from sources other than my primary care physician and/or his colleagues.
    f. If test results indicate the improper use of prescribed medications or the use of illicit drugs.
    g. I violate any of the terms of this controlled substance contract.
19. Recreational Marijuana has been legalized in the Commonwealth of Massachusetts, however, we do not recommend the use of marijuana along with controlled substance medications. Use of recreational marijuana, while under contract for an opioid medication, will be considered a violation of your controlled substance contract.
20. If my primary care physician or prescribing physician needs to discontinue my controlled substance, the dose will usually be reduced slowly over several days. If my primary physician believes that I have a drug addiction problem, I may be referred to another health care provider for management of that dependency.
21. I understand that I must abstain from use of illegal drugs or alcohol while under treatment by my primary care physician or prescribing physician.
22. I understand that I must keep scheduled appointments. Frequently missed appointments or same day cancellations with any of my providers may result in termination of treatment.
23. I understand that I may not be allowed to drive or operate equipment that may put me or others at risk during periods of medication adjustment.
24. I understand that I must keep all of my medication in a safe or locked box in a secure area.
25. Personal Primary Care & Weight Management recommends that I limit my discussion of my controlled substance to my doctors and immediate family members.
26. I understand that any form of abusive behavior (including abusive language) toward office staff will not be tolerated and will constitute a termination of this contract and/or immediate dismissal from the practice.
27. I will inform my provider if I am taking any other medications including herbal remedies and over the counter medications.
28. I must be evaluated on a regular basis, as required, by my provider.
29. Controlled substance contract violations are permanent. Personal Primary Care & Weight Management will be prohibited from prescribing any future controlled substances.

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I have read this document, understand it, and have had all questions answered satisfactorily. I voluntarily consent to the use of controlled substances to help control my condition, and I understand that my treatment with controlled substances will be carried out in accordance with the conditions stated above. I am not currently suffering from any condition or under the influence of any substance that affects my ability to understand and agree to the terms of this consent.

Patient Signature ______________________________ Date ______________

Witness ______________________________ Date ______________

PHYSICIAN CERTIFICATION: I certify that the above named patient or responsible individual has received from me an explanation of the treatment and medications to be prescribed, including the risks and benefits associated there with. I have disclosed alternative methods of management that might be appropriate for the patient. I have offered to answer any question by this patient/ responsible individual regarding the procedure and/or medications. The patient acknowledged to me that he/she understood the information provided and voluntarily consented to the provisions herein.

Provider Name ______________________________

Provider Signature ______________________________ Date ______________

INTERPRETER'S STATEMENT: I have translated the information and advice presented orally to the individual giving consent by the provider. The patient or responsible individual acknowledged that he/she understood the information translated and voluntarily consented to abide by the terms of this agreement.

Interpreter Signature ______________________________ Date ______________