Patient/Provider Agreement for Controlled Drug Prescriptions*

The following items numbered 1 to 4 are the same for Acadia Hospital, Bucksport Regional Health Center, The Center for Family Medicine, Community Health and Counseling Services, Eastern Maine Medical Center, Health Access Network, Penobscot Community Health Care and St. Joseph Healthcare.

1. **We wish to have clear, shared goals for your treatment.**
    a. I am being treated with controlled drug for a diagnosis of _____.
    b. The goal of my treatment is to improve my function. .
2. **We want you to be safe in taking these drugs.**
    a. I should take controlled drugs only as prescribed. I will not change the dose unless directed by my provider.
    b. I will not give or sell these drugs to anyone.
    c. I will store these drugs safely so that they cannot be stolen or taken by other people. I know that lost or stolen drugs will not be replaced.
    d. If I have unused drugs I will dispose of them by dissolving them in water mixed with kitty litter, through drug drop off sites (local police) and through drug take back days
    e. I will notify my provider if I receive controlled drugs from other providers.
    f. I will not use controlled drugs which are not prescribed for me and I will not use illegal drugs.
    g. I will use only one pharmacy for controlled drugs. I will notify you if that pharmacy changes.
    h. I agree that my provider may share information about my use of controlled drugs with my pharmacy, with emergency rooms and with other providers involved in my care.
    i. I agree to keep my appointments and to notify my provider and reschedule when I must miss one.
    j. I agree to notify my provider if my health changes in an important way or if I become pregnant.
    k. I will sign releases so that my provider can share information with all other providers involved in my care.
3. **We must monitor these medicines carefully.**
    a. I agree to be called randomly for pill counts, and to present for a pill count on the same day on which I am contacted.
    b. I agree to be called randomly for urine drug tests, and to present for a urine drug test on the same day on which I'm contacted.
    c. I understand that if I cannot be reached for pill counts or urine drug tests my drugs may be stopped.
    d. I understand that if I lose my drugs or they are stolen my drugs may be stopped.
    e. I know that my provider and/or a team member will regularly look at the Prescription Monitoring Program to review all of my prescriptions for controlled drugs.
4. **We want to manage these prescriptions in an orderly manner.**
    a. I know prescriptions will be for 28 days at most, with no refills.
    b. I know I can only request refills on weekdays, during regular office hours, consistent with office policy.
    c. I know that I may not request early refills.

In addition {NAME of ORGANIZATION} policy also requires that:

-
-
-
-

I know that I must meet all of the requirements of this agreement or my controlled drugs may be stopped.

Name	**Date**
Provider	**Date**

*These standards were developed through a collaborative effort of clinical leaders from Acadia Hospital, Bucksport Regional Health Center, The Center for Family Medicine, Community Health and Counseling Services, Eastern Maine Medical Center, Health Access Network, Penobscot Community Health Care, and St. Joseph Hospital under the auspices of the Community Health Leadership Board.

Adopted on November 9, 2015