**DrJSeniorCare Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_**

**AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS**

The long term use of controlled substance prescriptions may cause addiction and, if used incorrectly, can lead to harmful side effects including death. Medications are only one part of the treatment for (check all that apply): Pain Anxiety ADHD/ADD Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



I understand that the goals of my medications are to improve my ability to function by my helping my underlying condition(s) as much as possible while understanding the risk of dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury including respiratory depression leading to death (especially if alcohol, benzodiazepines, and opioids are combined).

2. I may get addicted to this medication.

3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.

4. If I need to stop any controlled medications, I must do so slowly and under medical direction or I may get very sick.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I understand that if I do, my treatment will be stopped. I will not take anyone else’s medicine. I will keep my medicine safe, secure, and out of the reach of children.

2. I will take my medication as instructed and not change the way I take it without first talking to my medical provider. This includes taking more medicine than is prescribed.

3. I understand that my medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed. A police report is required for any stolen medication before any refills will even be considered. Refills will not be made during after-hours calls but only during a scheduled appointment with my primary DrJSeniorCare medical provider. I will keep track of my medications understanding that no early or emergency refills may be made.

4. I will keep all appointments set up my medical provider. I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a DrJSeniorCare staff member immediately.

5. I may be asked for a pill count where I will need to present to my pharmacy within 24 hours for a counting of my remaining drugs to ensure that medications have not been sold or used improperly. If I do not present within 24 hours for a pill count, my treatment may stop.

6. I agree to give a blood or urine sample, if asked, to test for drug use.

7. I will treat the DrJSeniorCare staff respectfully at all times. I understand that if I am disrespectful to staff or behave in a threatening manner, my treatment will be stopped.

8. I will sign a release form to let my DrJSeniorCare Team speak to all other medical providers that I see.

9. I will tell my DrJSeniorCare Team all other medicines that I take, and let them know right away if I have a prescription for a new medicine.

10. I will only use one pharmacy to get any controlled substance prescriptions as outlined in my chart. My DrJSeniorCare Team may speak to the pharmacist regarding my prescriptions.

11. I will not get any opioid pain medications (Lortab, Norco, Percocet, morphine, oxycodone, Dilaudid, hydrocodone, etc.) or other controlled substance prescriptions that can be addictive such as gabapentin, muscle relaxants, appetite suppressants, benzodiazepines (Klonopin, Xanax, Valium, Ativan) or stimulants (Ritalin, amphetamine) without telling a DrJSeniorCare Team Member BEFORE I FILL THAT PRESCRIPTION. I understand that I can call the CareConnnect.Love number 615-562-1411 at anytime to discuss any new prescriptions.

12. I will not use illegal drugs or street drugs. I understand that if I do, my treatment may be stopped.

13. I understand that I may lose my right to treatment under DrJSeniorCare.Love if I break any part of this agreement and/or my medical provider decides that the medication is hurting me more than helping me, and that this medication will be stopped by my medical provider in a safe way.

14. I have discussed the above with my medical provider and have been allowed to ask questions. I understand the rules above. I understand that my medical provider will monitor me carefully and may stop medications if the risk is considered to outweigh the benefit. I understand that controlled substances have risks, but with the intention of improving my quality of life as well as function, I agree with my medical provider that the benefits outweigh the risks.

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DrJSeniorCare Member Signature Date

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DrJSeniorCare Member Responsible Party Signature Date

Verbal Consent Obtained from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ On \_\_\_\_\_\_\_\_\_\_\_ Date

By (DrJSeniorCare Staff who obtained consent):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason Responsible Party gave consent if DrJSeniorCare Member unable