

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Patient-Provider Agreement for Controlled Substance Medication (Ongoing Use)	BIRTHDATE NAME REG NO
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Date: _____

The use of the following medicine(s) _____
(list medicine names)

Is only one part of my treatment for: _____

Primary Prescribing Doctor: _____

What should I know about this medication?

This medicine may help me.

Controlled substance medications often have side effects, which may include but are not limited to:

- Itching
- Rash
- Severe constipation
- Trouble urinating or passing stool
- Depression getting worse
- Problems thinking clearly

Anxiety & Sleep medicine(s) can cause:

- Dizziness
- Memory problems

Combining drugs can cause:

- Overdose
- Trouble breathing
- Death

Stimulant medicines (such as for Attention Deficit Hyperactivity Disorder (ADHD) can cause:

- High blood pressure
- Fast or irregular heart beats

I could become addicted to this medicine.

If I must stop this medicine for any reason, I need to stop it slowly. Stopping it slowly will help me avoid feeling sick from withdrawal symptoms. If I decide to stop my medication, I will contact my doctor.

If I or anyone in my family has ever had drug or alcohol problems, I have a higher chance of getting addicted to this medicine.

If I take this medicine and drink alcohol or use illegal drugs I:

- May not be able to think clearly
- Could risk hurting myself (such as a car crash)
- Could become ill or even die

My doctor can only prescribe this medicine if I do not use illegal drugs.


If I do not use this medication exactly as prescribed, I risk hurting myself and others.

I will not increase my medicine dose without being told to do so by my doctor.

This medicine will not be refilled early.

I am in charge of my medicine.

- I know my medicine will not be replaced if it is stolen or lost.
- I will not share or give this medicine to other people.

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What can I do to help?

- Bring my pill bottles with any pills that are left to each clinic visit.
- When asked, I will give a urine and/or blood sample to help monitor my treatment.
- Go to appointments and tests set up by my doctor. These may include physical therapy, x-rays, labs, mental health, etc. If I miss my appointments, it may not be safe for me to stay on this medicine. If I miss appointments, my doctor may want an office visit before giving refills.
- Be on time for appointments. If I am late to an appointment for prescription refills, my appointment may be re-scheduled. I may not be given my prescription until I am seen by my doctor.
- If I arrive late to an appointment for prescription refills, my appointment may be re-scheduled. I may not be given my prescription until I am seen by my doctor.
- Give my doctor permission to talk to my pharmacy. My doctor will check my prescription fill history by State Pharmacy registries and may call my pharmacy.
- If my doctor decides that the risks outweigh the benefits of this medicine, my medicine will be stopped in a safe manner.

How can I get my prescriptions?

- I can only get this prescription from my primary doctor's office.
- I cannot get this medicine from other providers (including the Emergency Department), without checking with my primary prescribing doctor.
- Controlled-substance prescriptions are monitored. These prescriptions often need a paper-prescription signed by my doctor that cannot be mailed, faxed, or called to pharmacy. This type of prescription takes 24 hours before it will be ready for pick-up from clinic.
- I will only use one pharmacy to fill these prescriptions.
 - The name of my pharmacy is: _____
 - My pharmacy's phone number is: _____
 - I will tell my doctor if I change pharmacies.

Refills will be given only during normal office hours.

Clinic policy prevents on-call doctors from giving controlled-substance prescriptions. No refills will be given when the office is closed.

I know that unless my doctor tells me otherwise, I need a scheduled appointment to get prescription refills.

If my doctor decides it is safe for me to get a refill without an appointment, only I or someone I choose [insert name] _____ can pick up a prescription from the clinic. This person may be asked to show ID.

What are reasons for ending the agreement?

I may not be able to obtain controlled prescriptions from the University of Michigan Health System if I do not follow this agreement.

I may not be able to be seen in the University of Michigan primary care clinics (including discharge from this clinic) if I am disruptive or threatening towards staff, or if I engage in illegal activities with prescriptions.

I know that by State of Michigan law, non-medical use of controlled substances (lying to get medications, or giving or selling these medicines to others) is a crime.

Patient Signature: _____ Date: _____

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