Fern River Psychiatry

CONTROLLED MEDICATION AGREEMENT

I, _____, have agreed to use the following medication as part of my treatment:

_____

(medication)

I understand that I have the following responsibilities:

- I will take medications at the dose and frequency described.
- I will arrange for refills at the prescribed interval only during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
- I will obtain all refills for these medications only at _____ pharmacy (phone #: _____), and consent for my doctor and my pharmacist to exchange information in writing or verbally.
- I will not request prescriptions for these medications from other healthcare professionals.
- I will inform my doctor of all other medications I am taking. I will inform my other health care professionals that I am taking these medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
- I will protect my prescriptions and medications. I understand that lost, misplaced, stolen, or damaged prescriptions will not be replaced.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- I will participate in any medical, mental health or substance abuse programs agreed upon with my doctor.
- I will not use illegal street drugs or another person's prescription.
- I will consent to random drug screening and/or pill counts, to assure I am taking only prescribed medications as directed, safely and appropriately.
- I will keep all of my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.
- I understand that my doctor may stop prescribing the medications if:
  - The medication does not lead to an improvement in my symptoms.
  - The medication causes significant side effects.
  - My condition improves such that I no longer require this medication.
  - I do not abide by the above terms of this contract.

_____ _____

Signature of Patient or Authorized Representative | Date / Time

_____ _____

Printed Name of Patient or Authorized Representative | Relationship of Authorized Representative

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