PATIENT INFORMED CONSENT AGREEMENT FOR CONTROLLED SUBSTANCES

The following agreement relates to my use of controlled substances prescribed by a physician and filled at ______________________ (Pharmacy). CARE Pharmacies and staff have a common treatment goal: to improve my ability to work and/or function. I recognize that the use of controlled substances is regulated and monitored by local, state and federal agencies and that the pharmacy carefully adheres to these regulations.

1. Altering or forging a prescription is a felony and will be reported to the authorities immediately.
2. I will not expect to receive additional medication before my next scheduled refill.
3. I will be responsible for storing my controlled substance medications in a “child-safe” place.
4. I will be responsible for reporting any stolen prescriptions or medications to the police and my physician.
5. I will take my medication as directed. If I abuse or alter the medications in any way the Pharmacy cannot be held liable.
6. I am aware that if I am taking prescription narcotics/controlled substances (orally, by patch, or via infusion pump), muscle relaxants and/or tranquilizers that the manufacturer of the drug(s) recommends not operating heavy machinery (this includes a motor vehicle). The Pharmacy cannot advocate that I act against the manufacturer’s recommendations and will assume no liability should I decide to do so.
7. I am aware that I could be charged with DUI should I choose to drive.
8. Opioids may interact with other drugs and are only safe to use with other drugs under a physician’s supervision. Typically they should not be used with substances such as alcohol, antihistamines, barbiturates, benzodiazepines or any mind-altering substances. These drugs slow down breathing and their combined effects could risk life-threatening respiratory depression.
9. I understand that increasing my dose on my own could lead to a drug overdose causing severe sedation, respiratory depression and death.
10. I will read the patient advisory leaflet that is included with my prescription. If there is anything I do not understand I will ask the pharmacist to clarify.
11. I understand that the opioid medication is strictly for my own use. I understand the taking of medications by anyone other than for which they are prescribed that results in an emergency situation, overdose, or dependence is NOT the responsibility of the Pharmacy.

(continued)
12. I understand that if any medications are paid by a check that is returned from the bank for any reason, it is grounds for dismissal from the Pharmacy.

13. I understand that my medications are to be prescribed for one pain center only. Prescriptions from multiple providers will be reported to each practice.

14. I understand that all my controlled prescriptions will be filled at one Pharmacy. Controlled prescriptions filled at multiple pharmacies will be reported to my pain center.

15. I understand that the pharmacist on duty will use their professional discretion to fill my prescription; this includes not filling the prescription based on factors pertaining to the prescriber and/or patient.

16. I understand that I will provide a **VALID ID** when presenting and/or picking up my prescription.

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I, _____________________________________________________ have read the above information, or it has been read to me and all of my questions regarding opioid medications have been answered to my satisfaction. I agree to abide by all the statements contained in this agreement.

______________________________    __________________
Patient Signature         Date

______________________________
Witness Signature

______________________________
Pharmacist Signature