Prescription controlled substances have significant risks, including death. I have discussed these risks with my provider and I have reviewed the Fact Sheet I have been given. Controlled substances also are subject to the restrictions provided by various federal and state laws. The purpose of this agreement is to help me stay safe when taking these medications and to help me and my provider comply with the law regarding these controlled substances while at the same time managing my pain or other conditions.

This agreement is for the treatment of my chronic condition(s) only and is not applicable to prescriptions for short-term treatment for a severe injury, surgery, or medical procedure.

**PATIENT RESPONSIBILITIES:**

* Controlled substances can be dangerous, especially if used in the wrong way. If my medication use becomes unsafe, I understand that my provider may stop prescribing these medications.
* I will only take the number and type of medication(s) prescribed to me. We will work together to change them if they are not meeting our agreed-upon goals.
* I will see my provider regularly to monitor my health and safety. I will keep my scheduled appointments in order to continue receiving my prescription. If I need to reschedule, I will notify the office.
* For my safety, my provider will ask me to participate in random urine or blood tests to make sure that I am taking my medications in a safe way.
* Mixing certain drugs can be unsafe. I will not use street drugs or medications that have not been prescribed to me. I will avoid consuming alcohol when taking my medications.
* I will inform my provider of any other drugs I am currently taking, including marijuana or other sedating medications. My provider may adjust or change my medications if she or he believes mixing certain medications is unsafe.

* If I have a problem, or if my medication is not working, I will talk to my provider before I do anything differently with my medication(s).
* I will not ask for refills earlier than agreed, as this is a sign that I am taking more than we agreed on, which could be unsafe. I will expect my refill requests to be reviewed during regular office hours and I will give my provider at least 3 business days to process refills. I understand my provider will not provide early refills if my medication is lost or stolen.
* I understand that taking controlled substances can result in developing addiction and/or physical dependence.
* My pills are for me only. I will keep them in a safe place away from children and others. I will also get rid of leftover pills by dropping them off at a pharmacy’s safe disposal site.
* I understand that giving or selling medications to others willendanger the health of others and is against the law.
* To the extent possible, I will obtain all controlled medications at one pharmacy. I will inform my provider if I change my pharmacy.
* I will be respectful of all office and pharmacy staff.
* My Cedars-Sinai treatment team will be the sole source of the following controlled substances prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am obtaining the following controlled prescriptions from other providers (please list other controlled substances currently taking): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROVIDER RESPONSIBILITIES**

* My provider will help me manage my chronic condition in the safest way possible and will educate me on the risks and benefits associated with the use of controlled substances.
* For my safety, if I develop symptoms of addiction, my provider may discontinue my medication by lowering my dose or stopping my medication. My provider may recommend a drug-dependency treatment program or refer me to a specialist.
* California law requires my provider to check a state database about all controlled substances prescriptions given me.

**SAFETY AGREEMENT**

\_\_\_\_I acknowledge that my provider may stop prescribing controlled substances if:

1. I do not show any improvement in my condition
2. I develop rapid tolerance or loss of improvement from the treatment
3. I develop significant side effects from the medicine
4. I do not submit to urine or blood drug screening when requested by my provider
5. I fail to make appointments at the recommended time period
6. If my provider determines for any other reason that the medicine is not advisable
7. I am mixing other drugs, alcohol, or medications which my provider thinks are unsafe
8. I fail to adhere to the responsibilities outlined in this agreement.

I have read this form and agree to the terms. I have had an opportunity to ask my provider questions about controlled substances and about this agreement. I have received education about the risks and benefits of my controlled substance prescription(s). I am signing this form voluntarily and have full right and power to be bound by this Agreement.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Original: To Chart Copy: To Patient