Ohio Wesleyan University

Ohio Wesleyan University Student Health Center

Controlled Substance Management

Patient/Doctor Agreement

This Agreement will provide you with information about certain controlled substance medications that may be prescribed by your doctor. This includes, but is not limited to: pain medications, such as opioids or tramadol; stimulant medications, such as amphetamines; benzodiazepines; barbiturates. These medications may be dangerous and addictive, and it is important that both you and your doctor act in a way that benefits your wellbeing and is in compliance with safe medicine practices as well as the policies of this medical practice. Use of these controlled substance medications is strictly controlled by local, state and federal governments.

By signing below, you, the undersigned patient (or parent/guardian), agree to the following:

I understand that I will need to be seen on a monthly basis for 3-6 months after receiving my initial prescription for an ADD medication from the Health Center and then every 2 months if my condition is stable. All other controlled medications will be given in small amounts and close follow-up will be necessary.

I understand that stimulants may lead to sudden death in adolescents with congenital heart defects, therefore, all patients receiving their first prescription/refill for stimulant drugs at the Health Center will need a family history, physical exam and possibly an EKG (this is at the discretion of the MD). The charge for an EKG is $50.00 and the cost will be applied to my Student Account if needed.

I understand that increasing the dose of my controlled substance medications without the close supervision of my doctor can lead to drug overdose, in some cases causing over sedation, respiratory depression, or death.

I understand that decreasing or stopping my controlled substance medications without the close supervision of my doctor may lead to withdrawal.

Side effects may occur at the beginning of my treatment and often go away within a few days.

Withdrawal symptoms may occur 24-48 hours after the last dose and may last up to several weeks.

Patient initials_____

Side Effects of Stimulants	Side Effects of Opioids, Benzodiazepines
• Headache • Decreased appetite /weight loss • Increased anxiety/nervousness • Insomnia • Twitching, involuntary tics • Irritability	• Nausea • Vomiting • Drowsiness • Constipation • Mental Slowness • Flushed Skin • Sweating • Itching • Difficult urinating • Jerking muscles
Withdrawal symptoms of Stimulants	Withdrawal symptoms of Opioids, Benzodiazepines
• Drowsiness • Depression • Disrupted sleep patterns	• Yawning •Sweating • Watery eyes •Aching muscles • Hot and cold flashes • "Goose flesh" • Runny nose • Anxiety • Tremors • Abdominal Cramps • Diarrhea

I will let my doctor know if any of these side effects are severe or do not go away. I will notify my doctor immediately if I need to visit another doctor or emergency room for any controlled substances medications, or if I become pregnant.

I understand that many drugs, prescription or over the counter, may interact with my controlled substance medications, and may cause serious side effects. Effects of drug interactions may include:

- Extreme fatigue or sleepiness
- Slowed breathing
- Low blood pressure
- Death

Patient initials_____

I will tell my doctor about all medications that I am taking. I will ask all doctors that I see for treatment about possible drug interactions with my controlled substance medications whenever ANY new medication is prescribed. I know that physical dependence may be expected after long-term use of some controlled substance medications. Dependence means that chemical changes in the brain have happened in response to controlled substance medication therapy. I understand that if I suddenly stop taking a controlled substance medication on which I am dependent, it might cause a withdrawal syndrome.

Addiction is different from physical dependence. Addictive behavior includes using a controlled substance medication to obtain mental numbness or euphoria, "doctor shopping," and/or using manipulative behavior toward a doctor or other persons in order to obtain a controlled substance medication. If I begin to show signs of this behavior, I understand my doctor will slowly decrease my dose of controlled substance medications and then discontinue it.

Tolerance occurs when it is necessary to take higher doses in order to get the same medication-related effect. I understand that tolerance may develop with long-term use of some controlled substances.

This Agreement is for the following controlled substance types (check all that apply):

- ☐ Opioids for chronic, non-cancer pain (e.g. hydrocodone, oxycodone, morphine, methadone)
- ☐ Benzodiazepines (such as alprazolam, lorazepam, clonazepam)
- ☐ Stimulant medications (such as methylphenidate, amphetamine salts, dexmethylphenidate)
- ☐ Muscle relaxers (such as carisoprodol)
- ☐ Barbiturates (such as phenobarbital)
- ☐ Other: _____

I understand that my doctor will provide appropriate care to me based on this agreement. Because my doctor is prescribing controlled substance medications for the management of my chronic medical condition, **I agree to the following:**

I understand that if I do not follow this agreement, my doctor may no longer prescribe controlled substances for me. If this happens, my doctor will slowly decrease the dose and then discontinue the prescribed controlled substance, as necessary, in a medically safe manner, in order to reduce the likelihood of withdrawal symptoms. In addition, my doctor will recommend drug-dependence treatment program as appropriate.

Patient initials_____

I understand that I may not be prescribed controlled substance medications on my first visit to this medical practice. If I am a new patient to the office or if I have been seeing another provider for controlled substance medications, **I must bring or provide all medical records (including previous testing done for ADD medications) from previous doctors before my controlled substance will be refilled or prescribed.**

I will keep my doctor informed about the type and intensity of my pain or other symptoms, the effect of my pain or other symptoms on my daily life, how well prescribed controlled substance medications are relieving my pain or other symptoms, and any side effects of the prescribed controlled substance medications.

I will not use any illegal drugs (such as. Marijuana, cocaine) or abuse alcohol while being prescribed controlled substance medications.

I will not share, sell or trade my controlled substance medications. Any lost, misplaced, stolen, destroyed, altered or otherwise missing prescription or pills will NOT be replaced.

I will take my controlled substance medications only as prescribed, and I understand that taking them at a faster rate than prescribed may result in my being without medication until the next appropriate refill time.

I will not try to obtain, any controlled substance medications, including pain medications, anxiety medications, or a stimulant from any other doctor (including doctors in Emergency Rooms or Urgent Care Center) unless my primary doctor or Health Center doctor thinks it is necessary. I understand that Emergency Room and Urgent Care Center doctors are not under any obligation to prescribe or administer controlled substance medications to me. I understand Emergency Rooms and Urgent Care Centers have policies to limit the prescribing of controlled substance medications.

I will provide at least **5 business days advance notice for any controlled substance medication refills.** I understand that refill requests called in on a Friday may not be available until the following Wednesday. I understand that I will not be able to obtain refills after hours, on weekends, or holidays when the office is closed. "Walking in" is not acceptable; you MUST plan ahead and schedule an appointment accordingly.

I will fill my prescriptions for controlled substance medications at one pharmacy, as designated by me.

Pharmacy: _____

Address: _____

Phone #: _____

Patient initials_____

I authorize my doctor and my pharmacy to cooperate with any city, state or federal law enforcement agencies, including state Boards of Medicine or Pharmacy, in the investigations of any possible misuse, sale or other diversion of my controlled substance medications. I give my doctor permission to provide a copy of this Agreement to my pharmacy and agree to waive applicable privilege or right of privacy or confidentiality with respect to these authorizations and this Agreement.

I will submit to a random blood or urine drug test at least once a year and more frequently as requested by my doctor to make sure I am in compliance with my controlled substance medications program. I understand that the cost of these drug tests will be sent to my Student Account, I agree to be financially responsible for any additional costs relating to such drug tests (i.e. if a drug test was positive on the random screen, another more expensive urine or blood test will be ordered).

Any of the following will represent a failed drug test:

- Absence of prescribed controlled substance medications;
- Presence of controlled substance medications for which I do not have prescription; and
- Presence of any illegal drug (such as marijuana, cocaine, heroin).

If I am found to be intoxicated by my doctor or any other doctor, it is violation of this Agreement.

I understand that signing this Agreement does not guarantee that I will continue to be prescribed controlled substance medications.

The following are violations of this Agreement:

- Two missed appointments with Health Center doctor prescribing controlled substance medications in one semester's time.
- Receiving controlled substance medications from other providers, including the Emergency Room/Urgent Care Centers, unless approved by my primary or Health Center doctor.
- Filling controlled medications at more than one pharmacy.
- Failing or refusing a drug test at any time.
- Use of illegal or non-prescribed controlled substance medications.
- Selling, trading or misusing any controlled substance medications.
- Threatening or hostile language or behavior toward any physician, employee or patient of this practice.

Patient initials_____