Patient Name: ______________________________

Patient DOB: _______________________________

UHS Controlled Medication Agreement

The purpose of this agreement is to help prevent misunderstandings about certain government-controlled medications that you will be taking. This agreement will help you and your health care provider comply with state and federal laws regarding controlled medications.

Single Prescriber:

- I understand that all prescriptions for controlled medications must come from the provider whose signature is below or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception.
- I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider. In the event that I develop a serious acute medical condition that another health care provider, such as an Emergency Department provider, determines an adjustment to my controlled medication use, I will notify my UHS provider immediately of any changes.
- The UHS provider prescribing my medication has permission to discuss all diagnostic and treatment details with dispensing pharmacists and/or other professionals providing my health care, for the purpose of maintaining accountability.

Single Pharmacy:

- I understand that all controlled medications must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, UHS must be informed. The pharmacy I have chosen is:

  Pharmacy: ____ **Phone:**___________________

- I understand that my UHS provider and my pharmacy will cooperate fully with any city, state or federal law enforcement agency, including New York State's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize UHS to provide a copy of this Agreement to my pharmacy, other health care providers, emergency departments, and insurance carriers, as necessary.

Prescription Renewals:

- I will only request renewals of my controlled medications during weekday business hours, 8:00 AM-5:00 PM (Monday through Friday, except Tuesday, 9:00 AM-5:00 PM). Requests for renewals at other times will not be granted.
- I will give University Health Service at least 48 hours (2 business days) notice for medication renewals. If I do not give this notice, I understand that my prescription renewal may be delayed.
- Early renewals will not be given. Renewals will be based on my keeping scheduled appointments at a frequency determined by my provider.

738 Library Road · P.O. Box 270617 · Rochester, NY 14627-0472
585.275.2662 · 585.276.0149 *fax* · www.rochester.edu/uhs

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Using Medication as Prescribed:

- I will not share, sell or trade my medication with anyone.
- I will not adjust the dose or amount of controlled medications I take without first discussing and obtaining approval from my health care provider.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will safeguard my medicine from loss or theft. Lost, damaged, or stolen medicines will not be replaced.
- I will not consume excess amounts of alcohol, nor will I use any other legal or illegal controlled substances, including marijuana, cocaine, etc.

Unannounced Blood or Urine Tests:

- I will submit to an unannounced blood or urine test periodically as requested by my health care provider to determine my compliance with my program of controlled medicine use. Abnormal test results would be grounds for discontinuation of the prescribed medication. Refusal of such testing may also subject me to an immediate tapering/discontinuation of my medication.

I agree to the following:

- I understand that if I break this agreement, my UHS health care provider will stop prescribing controlled medicines for me. In this case, my health care provider may taper me off the medicine over a period of time, as necessary, to avoid withdrawal symptoms.
- I understand that I must make and keep at least one appointment per year with the UHS provider who is prescribing my controlled substance(s). More frequent visits may be required depending on the medication that is prescribed.
- I have thoroughly read this agreement and any question that I have concerning the agreement has been answered to my satisfaction by my UHS provider.

This agreement is entered into on this __________day of ______________, 20 _____.

Patient Name: ____ Date of Birth: ___/___/ ___
Please Print

Patient Signature: ____ Today's Date: ___/___/___

Prescribing UHS Provider Signature:_________________________________ Date ___/___/____

Witnessed by: ____ Date ___/___/____