South Central
Alabama Mental Health

Serving Butler, Coffee, Covington & Crenshaw Counties

Consumer Responsibility Agreement

FOR USE OF CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications can be very useful in treatment but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to improve quality of life and daily function. Because my psychiatrist is prescribing controlled substance medications as a part of my treatment plan, I agree to the following conditions.

CONSUMERS' RESPONSIBILITY:

- I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it **will not be replaced.** I will have to wait until my next scheduled refill date to obtain additional medication.

- I give permission for my psychiatrist/CRNP to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of coordinating care and maintaining accountability.

- I will notify SCAMHC staff (CRNP, nurse, therapist) if I receive controlled substances from any other provider (Primary Care Physician, dentist, etc.). Failure to notify us that you are on other controlled substances will be considered a valid reason for not prescribing controlled substances and will result in your medication being tapered and discontinued. The State of Alabama Prescription Drug Monitoring Profile (PDMP) will be utilized to ensure compliance with prescribed medications and to ensure that you are not receiving duplicate prescriptions or other controlled substances from other healthcare providers

- I will use **only one pharmacy** for my routine controlled substance prescriptions and that will be:

  Pharmacy Name: _____

  Location: _____

  Phone #: _____

- I will come to my scheduled appointments.

- I will take my medication as prescribed. DO NOT increase the amount of medication if you feel it is not helping. DO NOT suddenly stop taking your medication. This may result in serious medical complications or death.

- I agree to undergo **random urine or oral swab drug screens** as requested to ensure compliance with prescribed medications and to screen for the presence of other non-prescribed or illicit drugs. If you are asked to submit a drug screen and refuse, this will be considered to be a positive drug test and your medication will be tapered.

- I will comply with random **pill counts** as needed within a 24- hour notice. I will bring all my medication to my doctor's appointments in their original package or bottle. The medications will be counted and number of refills checked. The purpose of the pill count is to monitor medication usage. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus may result in medications being tapered.

- I will not give, share or sell my medications to any other person. This is illegal.
- I do not currently have problems with substance abuse (drugs and/or alcohol).
- I will inform my treating Psychiatrist/CRNP and/or counselor of any previous history of substance abuse or previous termination of care from any pain management clinic or because of substance abuse.
- I am not involved in the use, sale, possession, diversion, or transport of illegally obtained controlled substances and/or illegal drugs.
- Female consumers only: I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my OB/GYN doctor and the psychiatrist/CRNP to inform them. I am aware that there could be some adverse effects on my baby.

PRESCRIPTIONS:

- New medications will not be prescribed over the phone
- Changes in your prescription will only be made during scheduled office visits (this includes dose increases and change in medication)
- Telephone calls regarding controlled substances should be limited to reports of significant side effects, which will result in decreasing or discontinuing the medication only
- State law allows no more than a one-month supply of most medications to be given in a single prescription. You should not expect to receive additional medication prior to the time of your next scheduled refill

REFILLS OF MEDICATIONS:

- **Will be made** only during regular office hours Monday through Friday, in person during a scheduled office visit.
- **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location to avoid their theft.
- **Will not be made** as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow."

RISKS AND SIDE EFFECTS:

I understand that controlled substance medications have potential risks, the most significant being:

1. **Physical Dependence:** abrupt stopping of the drug may lead to withdrawal syndrome characterized by abdominal cramping, diarrhea and anxiety.
2. **Psychological Dependence:** or addiction, which means it is possible that stopping the drug will cause me to miss or crave it.
3. **Improper Use or Overdose:** of the substance can lead to sedation, respiratory arrest, cardiac arrest and death.
4. **Mental Changes:** may result in confusion, changes in thinking abilities and problems with coordination and balance.

While I take these medications it may not be safe for me to drive a car, operate machinery or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put others people at risk of being injured.

Other side effects include: nausea, constipation, sleepiness, decreased appetite, problems urinating, sexual difficulties and depression.

Seek medical attention right away if you experience heart palpitations, dizziness, lightheadedness, or fainting; or if you experience problems such as slow or shallow breathing, extreme tiredness or sleepiness, blurred vision, inability to think, talk or walk normally; and feeling faint, dizzy or confused.

TERMINATION OF TREATMENT WITH CONTROLLED SUBSTANCE:

If it appears to the psychiatrist/CRNP that there are no demonstrable benefits to my daily function from these medications, suspected addiction, rapid tolerance, loss of effect or significant and detrimental side effects, I will gradually taper my medication as prescribed by the psychiatrist/CRNP.

If a drug addiction problem is suspected, I may be referred to another healthcare provider for management of the addiction.

I will not hold any member of SCAMHC liable for problems caused by discontinuance of controlled substances, due to the previously mentioned conditions.

I understand that if I violate any of the above conditions, my treatment with controlled substance medications can be terminated. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians and pharmacist. **I am responsible** for any withdrawal syndrome that may occur do to my misuse of the controlled substance medications and/or termination of my care.

ACKNOWLEDGEMENT OF ACCEPTANCE:

I have read this document, understand it and have had all questions answered satisfactorily. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement. I have been provided a copy of this contract for me to keep.

Consumer/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

I certify that I have explained this contract including risks and benefits and answered any questions for the above signed consumer.

Psychiatrist/CRNP Signature _____ Date _____

Psychiatrist/CRNP Signature _____ Date _____

Psychiatrist/CRNP Signature _____ Date _____

I have translated the information and advice presented orally to the individual giving consent by the person obtaining the consent. To the best of my knowledge and belief, he/she understands this explanation.

Family Member/Significant Other Signature. _____ Date _____