Controlled Substances Medication Management Agreement

Provider: _____ Facility: _____ Date: _____

Patient Name: _____ **DOB:** _____ **MRN:** _____

Parent/Legal Guardian Name (if patient is under 18): _____

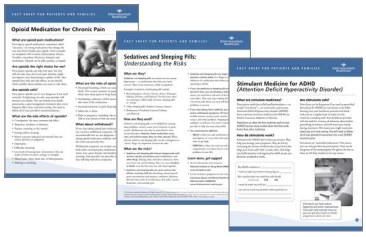
The terms "I", "my" and "you" in this document refer to the patient. Where the patient is under age 18, or an adult for whom a guardian is signing the Agreement, the terms "I", "my" and "you" refer to the patient and to his or her parent or guardian.

This document lists commitments you must make before you begin treatment with certain medications.

1. I have received and have read the following patient education:
   - ❑ Opioids *(Opioid Medication for Chronic Pain fact sheet)*
     - ❑ Education Video *(Opioids for Chronic Pain Management)*
   - ❑ Stimulants *(Stimulant Medicine for ADHD fact sheet)*
   - ❑ Benzodiazepines *(Sedatives and Sleeping Pills: Understanding the Risks fact sheets)*
   - ❑ Sedatives *(Sedatives and Sleeping Pills: Understanding the Risks)*
   - ❑ Hypnotics *(Sedatives and Sleeping Pills: Understanding the Risks)*
   - ❑ Others (Describe)

     _____ _____

     _____ _____



2. I have had the chance to ask questions and all of my questions have been answered in a way I understand.
3. I acknowledge that some medications have risks (even when taken alone) and that some medications can be more dangerous when taken with other medications. I will tell all of my healthcare providers about all prescriptions and all medications and supplements that I am taking or may take in the future.
4. I have discussed this medication with my healthcare provider. I understand and will follow all of my provider's instructions about this medication (including instructions about refills).
5. I will take this medication only as directed by the prescribing provider. I will not crush or chew my medications unless I have received instructions from my prescribing provider to do so.
6. I realize that treatment with this medication may require close monitoring, including development of a treatment plan. I will schedule all appointments my healthcare providers ask me to schedule, and will keep those appointments. I will attend and participate fully in any assessments, pain education, and treatment programs as recommended by my healthcare providers in my treatment plan.
7. While being treated with this medication, I will not use alcohol, marijuana, illegal drugs, or prescription drugs that have not been prescribed to me.
8. I will not drive or operate dangerous equipment while under the influence of controlled substances that may reduce my coordination or judgment. Whenever my medication makes me feel impaired in any way (including whenever I feel tired, dizzy, mentally foggy or unsteady), I will refrain from taking actions that could endanger myself or the public.
9. I am responsible for any lost or stolen medication. I will securely store my medications. I will not sell, share or trade them. I understand that my provider may not refill lost or stolen medication.
10. I agree to complete urine or blood testing whenever my healthcare provider asks me to do so.
11. My provider may decide to stop treating me with this medication if it is no longer an effective treatment method for me, or if I do not follow all parts of my treatment plan, including those described in this Agreement.

My signature confirms that I have had an opportunity to ask questions about this agreement, and that I understand and agree to all of the statements above. I have been given a copy of this Agreement and agree to keep the copy for my future reference.

Patient or Patient's Representative (required): _____ Date: _____

Mature Minor Patient*: _____ Date: _____

*(*Patients aged 12 to 17 should sign in addition to the parent or guardian.)*

Intermountain® Healthcare

Medication Management Agreement 50432

Patient and Provider Publications CPM034f - 10/16