WESTERN MONTANA
MENTAL HEALTH CENTER

Controlled Substances Treatment Agreement

Client Name:_____ Client Number:_____

This Agreement refers to medicines belonging to any of the following categories: Opiates, Opiate like (for example, Tramadol), Benzodiazepines, Hypnotics, and Stimulants

Controlled substances can be dangerous. If they are not used carefully, you can become addicted to them or overdose on them. An overdose can cause death. Because of these dangers, it is important for you to understand the rules for using these medicines. This document describes our policy for prescribing these medicines and what your role is to keep you and your family safe and to get the best results from your treatment.

Please initial each blank below indicating that you understand.

Parent/ Guardian	Self	(For clients between the ages of 14 and 18, both the parent/guardian and the client should initial)
		The risks, benefits, alternatives, and side effects of my controlled substance medicines have been explained to me and I understand the explanation.
		I understand that the medicines must help me function better. If my activity level or general function gets worse, my provider may change or stop the medicines.
		I understand medicines are only part of an effective treatment plan for me. I will also participate in other treatments that my provider recommends, such as behavioral health or physical therapy.
		I will take my controlled substance medicines the way my provider prescribed them. I will not change how I take these medicines without first talking with my provider.
		I will keep my controlled substance medicines in a safe place and away from children
		I will get prescriptions for controlled substance medicines only from my provider listed below (or his/her covering provider) and at _____ Pharmacy.
		I will tell other healthcare providers I see that I am taking controlled substance medicines.
		I will not get controlled substances medicines from other clinics or Emergency Rooms.
		I will make follow-up appointments as directed and will not miss appointments.
		I will not ask for extra or early refills of my controlled substance prescription if I run out early for any reason or if my controlled substance medicines are lost or stolen.
		I understand that refills will not be made as an "emergency". A minimum of four day's notice is needed for prescription refill requests to be processed.
		I understand that changes in prescriptions and refills will only be made during scheduled appointments and not by phone, which includes after clinic hours, on weekends, and holidays.
		I will not drink alcohol, use marijuana, use illegal drugs (for example, cocaine, heroin, methamphetamines), or use any controlled substances my provider did not prescribe for me.

Parent/ Guardian	Self	(For clients between the ages of 14 and 18, both the parent/guardian and the client should initial)
		I will not share, sell, or trade my controlled substance medicines with anyone.
		I will allow my urine to be checked to see what drugs I am taking at any time.
		I agree to bring my medicine(s) in their original bottles to the clinic when my provider requests this.
		I understand that, if there is reason to believe I have engaged in illegal activity, my provider may notify the proper authorities.
		I agree that my provider may contact other health care providers or pharmacists involved in my care to discuss my progress and to share information about this agreement.
		I am responsible for the safety of my driving and the operation of heavy machinery or power tools. I understand the medicine(s) may have sedating side effects and I will take the necessary precautions.
		(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance.
		(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately notify my provider. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will become dependent on the substance. I am aware that withdrawal from substances can be life threatening for a baby. If I am of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of my treatment with controlled substances.

I have had my questions answered and agree to follow each element of this agreement.

I understand that if I do not follow the agreement above, I will no longer receive controlled substance medicine prescriptions from any provider at Western Montana Mental Health Center.

Provider Signature	Date	Time
Provider Printed Name		

Client Signature (14 and over)	Date	Time
Client Printed Name		

Parent/Guardian Signature	Date	Time
Parent/Guardian Printed Name		