Student
Health and Wellness Center
(Student Health)

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

CONTROLLED SUBSTANCE CONTRACT

Patient Identification

Diagnosis:_____

Controlled Substance(s) Prescribed:_____

This contract is between you and your Student Health and Wellness Center healthcare team regarding the appropriate and safe use of your prescribed controlled medication(s). These medications include stimulants, benzodiazepines and opioids. These medications, although beneficial for the condition prescribed, also carry certain risks.

Due to these risks and the potential for abuse, we require you to read and sign this contract, thereby agreeing to the following conditions. Please initial each line.

_____ 1. I understand that Student Health reserves the right to review the Oregon Drug Monitoring Program website prior to refills, require more frequent office visits and/or require random urine drug screening (as determined necessary by my Student Health clinician team in its sole discretion). I am responsible for the cost of a urine drug screen if it is not covered or only partially covered by my insurance plan.

_____ 2. I understand that Student Health reserves the right to discontinue prescribing me controlled substances at any time.

_____ 3. While the clinicians at Student Health are prescribing my controlled substances, I will not seek controlled substances (stimulants, benzodiazepines or opioids) from other sources. If I require medical treatment for other conditions which may require these medications, I will communicate this with my Student Health clinician as early as possible.

_____ 4. I will take these medications as prescribed. If I use up my medications prior to the anticipated refill date, no change will be made in the refill amount or date, unless something has dramatically changed and only if approved by my Student Health clinician

_____ 5. I will alert my Student Health clinician if I wish to stop my medication as abrupt withdrawal of some medications may result in withdrawal syndrome.

_____ 6. I will not share, exchange or sell my medication, as the law prohibits those actions. I understand that my clinician will report serious concerns of drug misuse to the authorities.

_____ 7. I will not use illegal/street drugs or abuse alcohol.

_____ 8. I recognize that these medications by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my Student Health clinician if these symptoms arise. I will not drive or operate equipment if I experience these side effects.

_____ 9. It is my responsibility to keep my medications safe. If my medication is lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office.

_____ 10. I will need an office visit with a Student Health clinician for all refills of this medication. Therefore, it is my responsibility to plan ahead to make sure I have an appointment scheduled prior to needing a refill.

_____ 11. I will only obtain this medication from my preferred pharmacy.

_____ 12. I understand that my Student Health clinician may discuss all diagnostic and treatment details with dispensing pharmacists or other health care professionals who are providing treatment to me.

____13. (For Patients At Risk of Pregnancy) It is possible for controlled medications to affect the fetus or unborn child in a pregnant person. In the event that I become pregnant or plan to become pregnant, I will notify my Student Health clinician immediately.

Material Risk for the Prescription of Controlled Medications

Rationale: This contract and material risk statement is mandated by OAR 847-015-0030. The reason for this is that federal, state, and local government and law enforcement agencies pay special attention to these medications and the clinicians who prescribe them.

I understand that this contract is intended to clarify the manner in which the prescription of controlled medications will be used to manage my medical condition.

Potential Side Effects: I understand that there are potential side effects with the controlled medications that I have been prescribed (checked below) that I have been prescribed (checked below). These include, but are not limited to:

_____ OPIOIDS: sedation that may interfere with my ability to drive and operate machinery safely, breathing difficulty, seizures, decrease in blood pressure, constipation, nausea, vomiting, headache, dizziness, confusion, anxiety, abdominal pain, itching, mood changes and allergic reactions

_____BENZODIAZEPINES: sedation that may interfere with my ability to drive and operate machinery safely, breathing difficulty, fainting, seizures, increased risk of suicide, fatigue, confusion, double vision, appetite changes, low blood pressure, amnesia, constipation, urinary retention, elevated liver enzymes

_____STIMULANTS: psychosis, mania, aggressive behavior, arrhythmia, stroke, heart attack, seizures, growth suppression, rash, insomnia, tachycardia, nausea, motor tics, headache, palpitations, depression, chest pain, change in vision, elevated liver enzymes

Physical dependence is an inevitable consequence of controlled medication use. This involves the body's acclimation to the medication, thus the medication may become less effective over time. If someone who is physically dependent on a medication discontinues the medication abruptly, they may experience an uncomfortable and potentially life-threatening withdrawal syndrome.

Addiction is not the same as physical dependence, although the two may overlap. Addiction involves the compulsive use of a substance, against a clinician's instructions, for unintended

purposes. I agree to contact my clinician if I develop a craving for the controlled medication or a desire to use it for effects other than intended.

Alternative therapeutic options exist for the management of my condition, including no treatment. These alternative options may have different and/or fewer side effects. My Student Health clinician has provided me with information about alternative therapeutic options and my questions have been answered.

My Student Health clinician has asked me if I want a more detailed explanation of the above and if I have any additional questions. My questions have been answered. The treatment, alternative treatment and risks have been explained to me in substantial detail. I am satisfied with my clinician's explanations.

I have read, understand and accept all of the above terms.

Patient Signature_____ Date_____

Explained by me and signed in my presence:

Clinician Signature_____Date_____

Copy provided to patient on (date) _____