Long Term Treatment Agreement

_____(client's name) have been prescribed the controlled substance(s) named below for the management of_____ _____(diagnosis or condition).

Controlled Substance Medication:_____Date Prescribed:_____

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A consistent approach to your care using controlled substances is important.

I _____(primary provider) will be the primary person to prescribe your controlled substances. In the event that I am not available, one of the other providers named on this agreement will manage your prescription for controlled substance in my absence.

A. For the Provider(s) Prescribing the Controlled Substance:

Provider(s) Initials	All providers named agree to the following:
	You will be assessed and prescribed the most appropriate controlled substance as well as other supportive therapies to manage your diagnosis or condition.
	Your progress will be followed on a regular basis and adjustments will be made to the plan of care, when necessary.
	You will be given information and education, and your questions will be answered about the safe use and management of your prescribed controlled substance and other supportive therapies.
	You will be prescribed the dose and amount of controlled substance to appropriately manage your diagnosis or condition (both the initial dose and any changes to the dose that may be necessary).
	Refills for your prescribed controlled substance will be provided when there is evidence that you are taking the medication as prescribed.
	Requests for changes to the prescribed controlled substance will be based on a thorough assessment and review of the effectiveness of the therapy.
	Other (if applicable):

B. For the Client/Caregiver (if applicable):

I_____ (client name) understand that I am receiving _____(name of controlled substance(s)) from_____(provider name) for management of _____(diagnosis/condition).

By making this agreement, I agree to the following:

Client/Caregiver Initials	Client/caregivers (if applicable) agree to the following:
	I will receive prescriptions for my controlled substance only from my primary provider (or any alternate providers named on this agreement).
	I will inform my primary provider if I have requested and/or received a prescription for my controlled substance from another provider that is not listed in this agreement (e.g. an emergency situation).
	I will take my medication as prescribed. I will not change or increase the dose of my medication, take the medication more often or in a different way than prescribed without discussing it with my primary provider (or their alternate).
	If my prescription runs out early for any reason, I understand that I may have to wait until the next prescription is due.
	I will not give or sell my medication to anyone else, including family members.
	I will not accept any controlled substance from anyone other than those providers named on this agreement.
	I will not use over-the-counter medications containing a controlled substance, such as 222's or Tylenol® No. 1.
	I will check with my primary provider or pharmacist before taking other medications including over-the-counter and herbal products.
	I will avoid tranquilizers, sleeping pills, alcohol or illicit drugs (such as marijuana, cocaine, heroin or hallucinogens) as they can interfere with the actions of my prescribed controlled substance.
	I will keep all agreed appointments, treatments and consultations with my primary provider or other healthcare team members involved in my care.
	I will bring all medications to every appointment with my provider. I am aware that my provider may do a random count of my controlled substances.
	I will avoid driving a motor vehicle or operating dangerous machinery until I know that I am not experiencing any side effects from my controlled substance (e.g. nausea, drowsiness, etc.).
	I understand that some controlled substances can cause physical dependence, and decreasing or stopping the medication may lead to symptoms of withdrawal.
	I may be required to provide a random urine sample to monitor my medication use.
	I understand that my primary provider may communicate with other healthcare providers to manage my condition.
	I will store my medication in a secure location in my home and will not leave the medication in my vehicle or other open areas where others can access it.
	I will return any unused controlled substance to my pharmacy for disposal when it is no longer needed for managing my condition.
	Other:

...continued

B. For the Client/Caregiver (if applicable):

I will fill my prescriptions at the pharmacy noted below:

_____

I understand that if I do not follow this agreement, my primary provider (or their alternate) may choose to stop writing controlled substance prescriptions for me.

Patient Signature: _____Patient's Health Card Number: _____

Caregiver Name (Print): _____Signature: _____

Primary Provider (Print):_____Signature: _____

Alternate Provider (Print):_____Signature: _____

Alternate Provider (Print):_____Signature: _____

Alternate Provider (Print):_____Signature: _____

Date Agreement Established:_____

Date Reviewed / Initials:_____

Date Reviewed / Initials:_____