Short Term Treatment Agreement

For the Provider(s) Prescribing the Controlled Substance Medication:

I am prescribing a controlled substance medication to _____(client name) for the management of _____(diagnosis or condition).

Name of controlled substance medication:_____
Dose, frequency, duration and quantity:_____

I have discussed the actions and side effects of the medication being prescribed and answered all questions. I have provided_____copy(ies) of this agreement to_____ (client name); one for their own use and a copy for their primary provider.

For the Client/Caregiver Receiving the Controlled Substance Medication (if applicable):

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

I agree to take this medication as prescribed. I will not give, share or sell this medication to anyone, including family members. I will store this medication in a secure location. I will arrange to see my primary provider to discuss the reason I was given this prescription for a controlled substance and to obtain any refills or changes to the dose of the medication.

Provider Signature: _____Date: _____

Client/Caregiver Signature: _____

Patient's Health Card Number: _____