

# Agreement for Controlled Substance Prescription

Maia U. Chakerian, MD

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your physician to comply with the law regarding controlled medications.

Controlled substance medications (i.e., opioids, tranquilizers, and barbiturates) are very useful, but have the potential for misuse and addiction and are closely controlled by the state and federal government. Because my physician is prescribing such medication for me to help manage my condition, I agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription or medication is lost, or if I use it up sooner than prescribed, I understand that it **WILL NOT** be replaced. If the prescription is stolen, I must provide a police report and come in for an appointment before the medication **MAY** be replaced. If I will be out of town during my regular refill date, I will provide Dr. Chakerian with a printout of my itinerary from the airline, travel agent, hotel or other appropriate entity before an early prescription **MAY** be given.
2. If I receive a prescription for controlled medication from another doctor, I will notify Dr. Chakerian within 24 hours.
3. Refills of controlled substance medication:
  - a. **Will not be made as an emergency.** I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription.
  - b. Will be made only during Dr. Chakerian's regular office hours. Refills will not be made at night, on weekends or holidays
  - c. Will only be made if I keep my appointments and am seen regularly to monitor the effect and the usage Of my medication.
4. I will not share, sell, or trade my medication with anyone.
5. I agree that I will submit to a urine test if requested by my physician to determine my compliance with my program of pain control medicine. I understand that illegal substance may be detected on these test, and that I may not receive further prescription for controlled substance if I am found to be utilizing illegal substance or controlled medication that has not been prescribed by Dr. Chakerian.
6. I give permission for Dr. Chakerian to obtain information about my utilization of medications from other physician, any pharmacy and the Drug Enforcement Administration.
7. I understand that State law prohibits driving and operation of dangerous equipment while taking any sedating medication, even if I do not feel sedated.

***By my signature below, I acknowledge that I have read and understood this Agreement and agree to abide by its terms..***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Copy of agreement given to pt. \_\_\_\_\_ (initial/date)