

CHRONIC USE OF CONTROLLED MEDICATIONS

Recognizing that a small group of patients benefit from chronic anxiolytic usage, this policy is enacted to insure safe and proper use of these controlled substances.

1. Patient should have shown via a trial period of usage that their anxiety is controlled adequately and proper dosing is being followed.
2. Patients must be seen regularly in the clinic.
3. Patients must receive anxiolytic prescriptions only from one physician, and one pharmacy.
Please furnish the name and phone number of your pharmacy below:

4. No prescriptions will be filled over the phone.
5. Lost or stolen drugs or prescriptions will not be accepted as a reason for refill prior to the appropriate time period.
6. Changing doses without contacting the physician will terminate the prescribing relationship.
7. If medication abuse occurs, the drug will be stopped immediately, and the patient will be urged to enter a detoxification program.
8. Abuse of prescriptions by the patient will prompt notification of all pertinent area physicians and necessary legal authorities.
9. This mode of treatment will be stopped if any of the following occur:
 - I give, sell, or misuse the drugs.
 - The doctor finds me noncompliant with any of the conditions of this agreement.
 - I develop rapid tolerance or loss of effectiveness from this treatment.
 - I develop side effects that are significant in the view of the physician.
 - My functional activities decrease.
 - I obtain controlled medications from sources other than this physician.
10. Pregnancy may warrant discontinuance of medication therapy at the discretion of my treating physician and obstetrician.
11. I understand that the doctors of Primary Care Systems, Inc., will be reasonable but firm in interpreting all of the above conditions.
12. Patient will be required to perform random drug screens upon the physician's request.

I have read this agreement, understand it, and have all questions answered satisfactorily.
I CONSENT TO THE USE OF ANXIOLYTIC MEDICATIONS UNDER THE TERMS
OUTLINED IN THIS AGREEMENT.

Patient Signature

Date

Physician Signature

Date

Witness

Date

Medication: _____ Date & Time of Last Dose: _____