MiKiDS PEDIATRICS

CONTROLLED SUBSTANCE AGREEMENT

Patient Name _____ Date of Birth ____/____/_____

PCP _____is prescribing medication to help me manage my diagnosis(es) _____

1. I **will** schedule and come to appointments when asked to by my provider, including a med check 3 weeks after starting a new medication and every 6 months to monitor progress and if any changes are needed.
2. I **will not** share, sell, or trade prescribed medications with anyone.
3. I **understand** that combining "street drugs" (including marijuana), opiates like OxyContin, or alcohol with my prescribed medications may be dangerous. I will not use street drugs or take friends' prescribed medications.
4. I **will** give urine and blood samples to check for prescribed and non-prescribed medication in my body as requested by provider.
5. I **understand** that changing or forging prescriptions is a federal crime. If I change or forge a prescription, the police will be notified. I **understand** that selling (diverting) prescribed medications to others is a felony.
6. I **will not** get my prescribed medications from any other provider or clinic, except my office during regular office hours, without contacting the MiKids office to let us know there has been a change in management.
7. I **will not** take more of my prescribed medications than what my provider has instructed.
8. I **will not** call early for my refills.
9. I **will** bring my unused prescribed medications and the empty bottles when asked.
10. I **will** allow the office to monitor my prescribed medication use through the Michigan Automated Prescription System (MAPS), which allows provider to see what medications have been prescribed for me. I understand it is now state law in Michigan for providers to do this with every prescription written.
11. I **understand** that this Controlled Substance Agreement will become part of my electronic medical record and will be shared in the same protected manner as my other medical records.
12. I **will not** be disruptive or threatening toward office staff or pharmacy staff.
13. I **understand** that I should properly disposed of unused prescribed medications through accepted methods.
14. I **understand** that refills will need to be requested monthly, allowing at least 2 business days for request to be completed.

I have read this agreement, and I understand everything in it. By signing my name, I agree to follow it. If I do not follow this agreement, the office may stop prescribing medication for me. I understand that I must work with my medical team in a partnership to manage my health.

Patient Signature _____ Date _____

Parent Signature _____ Date _____

Provider Signature _____ Date _____