Controlled Substance Program Statement

Michigan Health Specialist is making a commitment to work with you in your effort to treat/manage your diagnosis while aiming for a better prognosis. To help you in this journey, we agree that:

MHS will assist in scheduling regular appointments for medication refills. If MHS has to cancel or change your appointment for any reason, you will be notified.

As your provider, we will make sure when prescribing controlled substance as part of your treatment process that they are safe as possible with minimal to no side effects. Narcotics are prescribed to manage/treat pain for an illness during the healing process.

MHS will keep track of your current prescriptions and test for narcotic/opiate and illicit drug use randomly and regularly to monitor your wellness and safety. It is up to the provider if you are discharged due to non prescribed medications and/or illicit drugs are within your system.

We will help connect you with other forms of treatment to help further improve symptoms related to your diagnosis. It is our duty to inform you there is potential that you become addicted to these medications. If you become addicted to these medications, we will help to facilitate treatment including tapering and/or stopping the medication safely.

Please remember that many of the medications we prescribe can often have adverse side effects. The pharmacy provides a detailed pamphlet with each medication listing the side effects. Potential side effects may include: dizziness, insomnia, respiratory distress, hives, blurred vision, drowsiness, loss/increase of appetite, stomach pain, nausea, muscle weakness, loss of balance, diarrhea, increased sweating, upset stomach, ear ringing, nervous or anxious feeling, flushed-redness, lightheadedness, itching, tired or irritable, headaches, memory problem, trouble concentrating, dry mouth, swelling of hands and/or feet, trouble of having an orgasm, lack of sexual desire, abnormal dreams, suicide thoughts, and homicidal thoughts and any other symptoms described in detail within your prescription paperwork. READ THE PAMPHLET THAT IS PROVIDED WITH YOUR MEDICATION AT THE PHARMACY and familiarize yourself with these potential side effects. Notify your provider immediately if you experience any adverse effects.

Thank you for working with us to treat you to best of our abilities. In the event of an emergency, you must report to Michigan Health Specialist within 24 hours if you receive a controlled substance. Paperwork must be presented along with the prescription bottle. If this occurs on Friday after 5 pm or on a close Holiday, you are required to the office the next business day. Regular hours are Monday through Friday 8:00 a.m. to 5:00 p.m.

Pain Management/Controlled Substance Contract

I understand that I have a diagnosis that currently requires treatment with the use of narcotic/pain management and /or other controlled substance to increase my ability to function while handling daily tasks and/ or decrease my pain.

The risk and the use of controlled substances has been discussed with me and is documented in my chart. I have reviewed/and will continue to review the disclaimers and paperwork associated with my medications. I am aware I should discuss with a pharmacist and my MHS provider any questions about the prolonged use of my medication and/or its side effects.

I understand the goal is for the provider and myself to work together to eventually be able to reduce my medication, to improve my ability to work and function, and to help my _____ (print name of condition) as much as possible without causing dangerous side effects such as opiate withdrawal such as nausea, muscle cramps, depression, agitation, anxiety, opiate cravings, mood changes, suicidal feeling and/or homicidal feelings.

I agree to the following terms:

__ I will keep all of my scheduled appointments with my provider and any other team members within and outside of the office that assists with my treatment plan. I will keep my balance up to date.

__ I will participate in all other types of treatment modalities as recommended by my provider. This may include seeing a specialist, physical therapist, imaging and/or mental health therapy if I am being treated for a psychiatric condition.

__ I will not schedule follow up appointments for medication refills for a controlled substance sooner than one month following my previous visit. I understand that no controlled substance will be filled over the phone and no early refills will be authorized.

__ I am responsible for my medications. I will not sell, share, and/or trade my medication. I will not increase my medication dose without consulting with and the approval of my provider.

__ If my medication is lost or stolen, I understand it will not be replaced until my next appointment when the refill is due.

__ I am subject to random and/or regular drug screens, either oral or urine. If I do not submit to the drug screen, my medications can be withheld.

__ I understand that my provider will obtain a MAPS report to monitor the control substance prescriptions that I have filled. A MAPS is a tracking report that details what controlled substances I have been prescribed and filled in the last year.

__ I will notify my provider if I become pregnant within 24 hours of a positive pregnancy test. Additionally, I will notify them if I am planning on becoming pregnant while on my medication. I understand I am subject to alterations of my medication while pregnant.

__ I understand I am subject to random pill counts as well as regular and random drug screens at any time.

__ I understand my provider may decrease or withhold my medication if my medication is not found in my system on a drug screening or if there is a concern for abuse.

__ I will not obtain any other controlled medications from any other providers. In case of emergency, my provider will be notified by myself immediately. I also agree that if pain medication is provided I will sign a medical release records for the provider that I have seen.

Termination of Agreement

If I break any of the above terms or if my provider decides that my medication is hurting me more than helping me, my medication may be stopped, decreased in dosage and/or quantity.

I have read and discussed this policy with my provider. I understand the above policy and agree to abide by these conditions. I also understand that this agreement is binding for one full year and I will be asked to sign another pain management agreement at the end of the one year, or at any time required by MHS. I understand this agreement terminates and replaces all other agreements, oral, written, or otherwise communicated. I understand Michigan Health Specialists reserves the right to change this agreement at any time.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Provider Signature: _____ Date:_____