(S)FM
Sparks Family Medicine, Ltd
Functional Medicine

Provider Controlled Substance Factors

Patient Name: _____ Date: _____

Provider Signature: _____

Factors to Consider Before Writing EACH CS Rx

Appropriateness	
1. Was the patient previously prescribed a CS? For what symptoms? Was it effective?	
2. Is the patient using other drugs, including alcohol and other controlled substances, that may interact negatively with the CS?	
3. Is the patient's presentation consistent with the patient's PMP report?	
4. Has the patient been reluctant to stop or reduce the CS or try other methods to address pain?	
5. Has the patient's health changed to affect the use of CS?	
6. Is there evidence that the patient is misusing or is addicted to the CS or other drug, including alcohol?	
Compliance	
1. Is there reason to believe the patient may not take or may divert the CS to another person?	
2. Has the patient attempted early refill of the CS? How many times? What were the reasons?	
3. Is there reason to believe that the patient is utilizing unauthorized CS?	
4. Has the patient demonstrated aberrant behavior?	
Medical History and Medical Records (if available)	
1. Have previous blood or urine tests indicate inappropriate CS use by the patient?	
2. Does the patient have a history of CS abuse?	
3. Are medical history and medical records consistent with patient presentation?	

To be completed and scanned into the patient's chart at each CS Rx visit.

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90-Day Controlled Substance Patient Assessment

Patient Name: _____ Date: _____

Provider Statement

The evidence-based diagnosis for the pain of this treatment plan:

_____

_____

_____

_____

_____ I have discussed the treatment plan with the patient.

_____ I will review the patient's PMP report at least every 90 days.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

To be completed and scanned into the patient's chart at 90-Day CS Rx visit.

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Controlled Substance Prescription Medication Agreement

Patient Statement

I, _____,
understand and voluntarily agree that (initial each section after reviewing):

_____ I will be compliant, including:

- Making sure the office has current contact information in order to reach me.
- Keeping (and being on time for) all my scheduled appointments at this office.
- Participating in all other types of treatment that I am asked to participate in.
- Taking my medication as instructed and not changing the way I take it without first talking to the office staff.
- Treating the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.
- Telling the provider all other medicines that I take, and letting the provider her know right away if I have a prescription for a new medicine.
- Using only the pharmacies on record at this office.
- Not getting any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a informing the office staff before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ I will be responsible in using a controlled substance, including

- Keeping the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.
- Making sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.
- Signing a release form to let the doctor speak to all other doctors or providers that I see.
- Coming in for drug testing and counting of my pills within 24 hours of being called.
- Informing the provider of treatments received for side effects or complications of medication.
- Not calling between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.
- Not selling this medicine or sharing it with others. I understand that if I do, my treatment will be stopped.
- Not using illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

States I have previously resided or had a controlled substance prescription filled:

_____

_____

_____

_____

To be completed and scanned into the patient's chart at 30-Day CS Rx visit.

Provider Statement

The goals of this treatment plan are:

_____

_____

_____

_____

- This office will terminate patients who do not comply with each of the patient statements on the previous page.
- If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set treatment goals and monitor your progress in achieving those goals.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

To be completed and scanned into the patient's chart at 30-Day CS Rx visit.