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Sparks Family Medicine, Ltd
Functional Medicine

Controlled Substance Questionnaire (NV Factors Version B)

Patient Name: _____ Date: _____

"N/A" means not applicable	YES	NO	N/A
1. Have you previously been prescribed a controlled substance?			
2. Have you ever used a controlled substance in a way other than prescribed?			
3. Have you ever diverted a controlled substance to another person?			
4. Have you ever taken a controlled substance that did not have the desired effect?			
5. Are you currently using any drugs, including alcohol or marijuana?			
6. Are you using any drugs that may negatively interact with a controlled substance?			
7. Are you using any drugs that were not prescribed by a practitioner that is treating you?			
8. Have you ever attempted to obtain an early refill of a controlled substance?			
9. Have you ever made a claim that a controlled substance or prescription was lost or stolen?			
10. Have you ever had blood or urine tests that indicated inappropriate usage of medications?			
11. Have you ever been accused of inappropriate behavior or intoxication?			
12. Have you ever been addicted to controlled substances or had difficulty stopping controlled substances?			
13. Have you ever refused to cooperate with any medical testing or examinations?			
14. Do you have a history of substance abuse of any kind?			
15. Has there been a change in your health that might affect your medications?			
16. Are there other factors your practitioner should consider before prescribing?			

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

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Controlled Substance Patient Discussion (Nevada Topics)

Patient Name: _____ Date: _____

The state of Nevada requires that providers discuss the following with patients before obtaining a Patient Informed Consent Form for controlled substances for pain management.

Your provider is required to address the following topics:

1. The potential risk and benefits of using controlled substances.
2. The proper use, storage and disposal of controlled substances.
3. The treatment plan implemented for your use of controlled substances.
4. Alternative treatment plans that do not include the use of controlled substances.
5. The risks to a fetus for exposure to controlled substances in women of childbearing age.
6. For opioids, the availability of an opioid antagonist.
7. For minors, the risks that the minor will abuse, misuse or divert the controlled substance and ways to detect those issues.

By your signature below, you are acknowledging that your provider has discussed the above topics with you, that you have had opportunity to you ask questions regarding these topics with your provider and that you have sufficient information to understand these topics related to the use of the controlled medications prescribed.

You should NOT sign this form if you do not believe you have sufficient information to understand these topics related to the use of the controlled medications prescribed.

Patient Name: _____

Patient Signature: _____

Provider Signature: _____

Date: _____

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

COMM™ Assessment

Patient Name: _____ Date: _____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	○	○	○	○	○
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	○	○	○	○	○
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	○	○	○	○	○
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	○	○	○	○	○
5. In the past 30 days, how often have you seriously thought about hurting yourself?	○	○	○	○	○
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	○	○	○	○	○
7. In the past 30 days, how often have you been in an argument?	○	○	○	○	○

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

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	○	○	○	○	○
10. In the past 30 days, how often have you been worried about how you're handling your medications?	○	○	○	○	○
11. In the past 30 days, how often have others been worried about how you're handling your medications?	○	○	○	○	○
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	○	○	○	○	○
13. In the past 30 days, how often have you gotten angry with people?	○	○	○	○	○
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	○	○	○	○	○
15. In the past 30 days, how often have you borrowed pain medication from someone else?	○	○	○	○	○
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	○	○	○	○	○
17. In the past 30 days, how often have you had to visit the Emergency Room?	○	○	○	○	○

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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.

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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?	

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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.