PATIENT – PHYSICIAN MEDICATION CONTROLLED SUBSTANCE AGREEMENT

VERY IMPORTANT – READ CAREFULLY BEFORE YOU SIGN!

PATIENT/ADDRESS: _____

CAREGIVER(S)/ ADDRESS(ES): _____

1.) ____ The patient/caregiver(s) agree(s) that all prescription renewals must be anticipated in a timely manner, that is within 7 (seven) days of prescription expiration or exhaustion in order to obtain a renewal, if deemed medically appropriate by the physician. Less than a seven day notice will likely result in a three to ten day delay in responding to the request, depending on physician availability.

2.) ____ The patient/caregiver(s) is responsible for informing the physician of the renewal within the time period above, either in person at follow-up or by telephone, **(505) 508-1543**, during regular business hours (8:30 a.m. – 4:00 p.m., MST). After hours, weekend and holiday requests will NOT be considered. Controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) prescriptions may only be picked up in person (must be over 18 y.o.) or by the patient's representative (must be over 18 y.o.), with proper picture identification (i.e., valid driver's license). It is the patient's responsibility to make arrangements and prepay a common carrier (e.g., Fed Ex/UPS) for those prescriptions that are to be sent by courier to the designated pharmacy.

3.) ____ The patient/caregiver(s) agree(s) to bring the MOST RECENT prescription container for EACH controlled substance (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) that requires renewal. The containers MUST correspond to the last prescription recorded in the medical record with the labels intact and legible so that appropriate control information may be documented by the physician in the medical record. Specifically, the prescription registration number and pharmacy telephone number will be noted and verified. The patient/caregiver(s) agree(s) to trade with only ONE pharmacy regarding controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) so as to facilitate this AGREEMENT. Where necessary, the patient must provide a readily verifiable reason for use of another pharmacy.

4.) ____ The patient/caregiver(s) agree(s) that in the event of a theft or loss of a controlled substance medication (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) medication or prescription, the local police must to notified and a copy of the OFFICIAL police report be brought to the physician's office which MUST include the Officer's printed name, badge number and telephone number of the police department making the report. Only then will the physician consider the request for a prescription renewal.

5.) ____ At the discretion of the physician, periodic patient NM State Board of Pharmacy (prior and current) medication profiles and/or random oral, blood and urine toxicology drug screens for controlled substances/medications of abuse as well as narcotic blood levels of the patient/caregiver(s) may be ordered to verify compliance with this AGREEMENT.

6.) ____ Should the patient receive controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol), such as NARCOTICS and SEDATIVES, from other providers, the undersigned physician's office MUST be informed by the patient/caregiver(s) WITHIN 72 HOURS of having filled the prescription. The following information will be given to the office: the provider's name and telephone number and the reason for the prescription.

7.) ____ Should the patient/caregiver(s) not adhere to or otherwise violate this AGREEMENT or furnish false information, then the patient may be discharged from the physician's care with two weeks notice being given immediately, in writing, sent to the patient's/caregiver(s)'s last address of record. Alternative consequences will be at the discretion of the physician.

8.) ____ Should the undersigned physician believe that I may have developed a medication use problem, I agree to undergo an evaluation by a physician specialized in the diagnosis of drug addiction or substance abuse disorders.

9.) ____ By my signature below, I ATTEST that I/caregiver am not in violation of or have not violated any other healthcare provider Controlled Substances Agreement, now or in the past.

SIGNATURES:

Patient: _____ Caregiver(s): _____

Date: _____ Prescribing Physician: John A. Campa III, MD

Witness: _____

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