



Patient Name:

Patient DOB:

University Health Services
University of Cincinnati
Lindner Athletic Center
2751 O'Varsity Way, 3rd Floor
Cincinnati, OH 45221-0010
513-556-2564

UHS Controlled Medication Agreement

The purpose of this agreement is to help prevent misunderstandings about certain government controlled medications that you will be taking. This agreement will help you and your health care provider comply with state and federal laws regarding controlled medications.

Single Prescriber:

- I understand that all prescriptions for controlled medications must come from the provider whose signature is below or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception.
- If I miss my regular appointment for follow up and renewal of my medication with my provider, I understand that I may be without my medication until my provider can be contacted.
- I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider. In the event that I develop a serious acute medical condition that another health care provider, such as an Emergency Department provider, determines an adjustment to my controlled medication use, I will notify my UHS provider immediately of any changes.
- The UHS provider prescribing my medication has permission to discuss all diagnostic and treatment details with dispensing pharmacists and/or other professionals providing my health care, for the purpose of maintaining accountability.

Single Pharmacy:

- I understand that all controlled medications must be obtained at the same pharmacy, whenever possible. The pharmacy I have chosen is:
- Pharmacy: _____ Phone: _____
- I understand that my UHS provider and my pharmacy will cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize UHS to provide a copy of this Agreement to my pharmacy, other health care providers, emergency departments, and insurance carriers, as necessary.

Prescription Renewals:

- Requests for renewals of my controlled medications will not be granted through the after-hours healthcare provider on call. However, I may use the online and/or phone prescription renewal request systems.
- I will give University Health Services at least 48 hours (2 business days) notice for medication renewals. If I do not give this notice, I understand that my prescription renewal may be delayed.
- Early renewals will not be given. Renewals will be based on my keeping scheduled appointments at a frequency determined by my provider.

Using Medication as Prescribed:

- I will not share, sell or trade my medication with anyone.
- I will not adjust the dose or amount of controlled medications I take without first discussing and obtaining approval from my health care provider.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will safeguard my medicine and my paper prescription from loss or theft. Lost, damaged, or stolen medicines and paper prescriptions will not be replaced.
- I will not consume excess amounts of alcohol, nor will I use any other legal or illegal controlled substances, including marijuana, cocaine, etc.

Unannounced Blood or Urine Tests:

My healthcare provider may periodically request an unannounced blood or urine test to determine my compliance with my program of controlled medicine use. Abnormal test results would be grounds for discontinuation of the prescribed medication. Refusal of such testing may also subject me to an immediate tapering/discontinuation of my medication.

I agree to the following:

- I understand that if I break this agreement, my UHS health care provider will stop prescribing controlled medicines for me. In this case, my health care provider may taper me off the medicine over a period of time, as necessary, to avoid withdrawal symptoms.
- I agree to show University of Cincinnati or government issued photo ID each time I pick up a prescription from the UHS office.
- I understand that no one else can pick up my prescription without prior authorization from me directly communicated to UHS.
- I understand that I must make and keep at least one appointment every six months with the UHS provider who is prescribing my controlled substance(s). More frequent visits may be required depending on the medication that is prescribed.
- I have thoroughly read this agreement and any question that I have concerning the agreement has been answered to my satisfaction by my UHS provider.

This agreement is entered into on this _____ day of _____, 20_____.

Patient Name: _____

Date of Birth: ____/____/____

Patient Signature: _____

Today's Date: /____/____

Prescribing UHS Provider Signature: _____

Date ____/____/____

Witnessed by: _____

Date ____/____/____