COMPLETE CARE

Controlled Substance & Transitional Care Agreement

Patient Name: _____

MR#: _____ **Patient DOB:** _____

Provider: _____

Condition Being Treated:

_____

Medication(s):

1. _____
2. _____
3. _____

Purpose of Treatment

The goal of controlled medication therapy is to support function and quality of life. Complete elimination of symptoms may not be possible. Treatment will be regularly evaluated for safety, effectiveness, and alignment with appropriate care.

Patient Responsibilities

I agree to the following:

1. Medication Use

I will take this medication exactly as prescribed. I will not change the dose or frequency without approval from my provider.

2. Monitoring and Safety

I agree to:

- Participate in random urine or blood drug screening when requested

- Allow my provider to review prescription history through the Prescription Drug Monitoring Program (PDMP)
- Provide accurate information regarding all medications I am taking

3. Prescribing and Pharmacy Use

- I will receive prescriptions for controlled medications only from this provider or clinic unless in an emergency
- I will notify my provider within 48 hours if another provider prescribes controlled medication
- I will use one designated pharmacy:

Pharmacy Name: _____

4. Refills and Medication Security

- Refills will not be provided early
- Lost, stolen, or destroyed medications will not be routinely replaced
- Refill requests must be made at least 48 hours in advance during business hours

5. Appointments and Treatment Participation

- I will attend scheduled appointments with my provider and any recommended specialists (e.g., behavioral health, physical therapy)
- Repeated missed appointments or lack of participation in recommended care may impact continuation of medication management

6. Comprehensive Care

I understand that medication is only one part of treatment and may be combined with other approaches such as therapy, physical activity, or behavioral support.

Medication Risks and Safety

I understand that opioid medications:

- May cause drowsiness and impair my ability to drive or operate machinery
- Carry a risk of overdose, especially when combined with alcohol, benzodiazepines, or other sedating medications

- May cause side effects such as nausea, constipation, itching, or hormonal changes
- Can lead to physical dependence and tolerance over time

I understand that combining opioids with benzodiazepines, alcohol, or other sedating medications may not be considered safe and may not be continued.

Treatment Expectations

- Medication therapy may not fully resolve symptoms
- Increasing doses may not improve outcomes and may prompt reassessment
- Continuation of controlled medications is not guaranteed and will be regularly reviewed

Transitional Care / Bridge Plan (If Applicable)

☐ This section applies to my care
☐ Not applicable

If applicable:

Due to scope of practice, safety considerations, or alignment of care needs, this provider will **not continue long-term management** of my controlled medication(s).

Bridge Prescribing Plan

The provider agrees to prescribe the following medication(s) on a temporary basis:

_____

_____

Duration of Bridge

☐ 30 days
☐ 60 days
☐ 90 days

End Date: _____

No refills will be provided beyond this timeframe.

COMPLETE CARE

Patient Responsibilities During Transition

I agree to:

- Actively seek and establish care with a new provider immediately
- Schedule an appointment as soon as possible
- Transfer care within the timeframe outlined above

Acknowledgment of Transition

I understand:

- This provider will not continue prescribing beyond this agreement
- This is a temporary accommodation to support continuity of care
- Failure to establish care elsewhere does not guarantee continuation

Changes to Treatment Plan

If concerns arise related to safety, effectiveness, or adherence:

- My treatment may be modified
- Medications may be tapered or discontinued
- I may be transitioned to another provider or level of care

Care Coordination

I give permission for my provider to communicate with other healthcare providers involved in my care as needed to support safe and coordinated treatment.

Acknowledgment

I have discussed the risks, benefits, and alternatives to opioid therapy with my provider.

I have had the opportunity to ask questions and understand the expectations outlined above.

I agree to follow this treatment plan.

A copy of this agreement has been provided to me.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____