*SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY*

**CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT**

**PURPOSE**

The purpose of this agreement is to ensure the clinically appropriate and safe prescribing of controlled psychotropic substances. This agreement pertains to Benzodiazepine-type drugs such as: Xanax, Valium, Ativan, Klonopin, Restoril, Ambien, Lunesta, etc. and Psychostimulant drugs such as: Ritalin, Concerta, Adderall, Vyvanse, Dexedrine, etc. Your Sanilac County Community Mental Health Authority (Sanilac CMH) prescriber will closely coordinate your treatment with your primary care practitioner and all other physician prescribers. A refusal to authorize coordination of care with your other physicians may interfere with the ability of your agency prescriber to recommend controlled psychotropic medications.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The individual in treatment freely and voluntarily agrees to the following:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree NOT to sell, share, or give any of my controlled psychotropic medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my medication prescription being terminated. I am aware that I may be required at random to submit to a pill count and/or drug screen periodically. I understand that if my test comes back positive it might affect my ability to get controlled substance medications. However, my clinical services through Sanilac CMH will continue as deemed clinically appropriate.
3. I agree that my prescription will be given to me at my scheduled visits with my Sanilac CMH prescriber. Missing my appointments can subject me to a drug withdrawal reaction. A parent, guardian or other previously designated individual may pick up my prescriptions as previously arranged.
4. I agree that the medication I received is my responsibility and I agree to keep it in a safe and secure place. I agree that lost medication will not be replaced regardless of why it was lost at the discretion of the prescriber. If the prescription cannot be filled until a later date, I will give it to the pharmacy to put in a file. I will not leave my medication in a public part of my home, leave the bottle open or store the bottle near water or children. I am aware that these medications can be very dangerous to children.
5. I agree not to obtain controlled psychotropic medication from any doctors, pharmacies or other sources without consulting and keeping my Sanilac CMH prescriber informed. Please be aware that a Michigan Automated Prescription System report is utilized to discern appropriateness of prescribing controlled substances.
6. I agree to carry my medication in its prescription bottle or carry a copy of the prescription label.
7. I understand that mixing controlled substances with alcohol, or other street drugs, or non-prescribed medications can be life-threatening and interfere with the intended efficacy of the psychotropic medications.
8. I agree to take my medication as instructed and not alter the way I take my medication without direction from my prescriber.
9. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate completely in my treatment plan as discussed and agreed upon with my prescriber and case holder.
10. I have been provided the opportunity to discuss this agreement with a Sanilac CMH prescriber and I agree that violation of any part of this agreement may be grounds for termination of the prescribed medication.

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Individual Served Date Medical Staff Signature Date

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🞏 Parent 🞎Guardian Date