Peter Wenger, MD
Richard Levandowski, MD
Richard Kim, MD
Jennifer Lhost, MD
Kaitlin Jackson, DPT

PRINCETON SPORTS & FAMILY MEDICINE

Cara Barlis, MD
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3131 Princeton Pike Bld. 4A, Suite 100
Lawrenceville, NJ 08648
P: (609) 896-9190 F: (609) 896-3555

Patient: _____

Date of Birth: _____

Medication: _____

At Princeton Sports and Family Medicine we are committed to working with you in your efforts to get better. Our providers have appointments available days, evenings, and Saturday mornings. We will check regularly to make sure you are not having side effects and your treatment is as safe as possible. We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well. We will help connect you with other forms of treatment to assist with your condition. We will help set treatment goals and monitor your progress in achieving those goals. We will communicate with any other doctors or providers you are seeing so that they can treat you safely and effectively. If you develop tolerance or addiction to medications, we can refer you for treatment and stop medications that are causing you problems safely, without getting sick.

Controlled Substance Policy

This is an agreement between _____ (patient)

and _____ (prescribing provider)

concerning the use of the controlled substance medication,

_____

To comply with state and federal regulations, Princeton Sports and Family Medicine, P.C. has developed the policy outlined in this agreement regarding the use of controlled substance medications. By signing this agreement, I am stating that I understand the risks and benefits of this class of medication as well as the policies of this practice regarding its use and agree to abide by these policies.

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Addiction: a chronic preoccupation with obtaining a substance, misuse of a substance despite negative consequences, and propensity for obtaining a substance through illegal means or use of other illegal substances to satisfy a need or craving.

Physical dependence: a physiological state of adaptation to a specific medication leading to a withdrawal syndrome during abstinence, which may be relieved totally or in part by re-administration of the substance.

_____ **I agree to comply with the following schedule for controlled substance prescription refills.** At their discretion, the prescribing provider may require appointments more frequently than the minimum written in this policy.

--- New prescription or change in dose: MONTHLY VISITS
--- Stable on medication/dose for 3 months: EVERY 3 MONTHS.
--- Anytime a dose is changed, the patient must resume MONTHLY visits until stable on a dose for 3 months

_____ **I will take the medication only as prescribed and will not adjust the dose without consulting with my provider.**

_____ **Each prescription will be written for a fixed amount of medication sufficient to last until the next visit. I agree not to change the dosage of my medication.** Dosage changes will be made only during office visits with the prescribing provider. Example: *A 30-day prescription should last 30 calendar days, starting from the first day that medication was filled at the pharmacy*.

_____ **I understand that if I am unable to schedule an appointment for refills, a 14-day bridge script may be issued, but no additional prescriptions will be issued until I have a visit.**

_____ **I understand that a replacement script will not be provided if my medications are lost or stolen until I am due for my next refill.** Please note: discrepancies with the amount of medication dispensed at the pharmacy must be addressed by the pharmacy, not the prescriber.

_____ **I understand that it is my responsibility to keep the medication in a secure place**.
If medications are stolen, a police report will be given to the prescribing provider and become a part of my medical record.

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_____ **I understand that the following are risks associated with the use of controlled substance medications and will immediately alert the prescribing provider should any occur:**

- Insomnia
- Irregularity of menstrual periods
- Nausea, constipation, and decreased appetite
- Depression, panic attacks and other mood changes
- Confusion, impaired memory, and problems with concentration
- Problems with urination and problems with sexual function (men and women)
- Sleepiness, drowsiness and problems with coordination or balance;
  making it unsafe to drive or operate machinery while using these medications.
- Allergic reaction (anaphylaxis) causing rash, hives or difficulty breathing;
  if left untreated this could lead to death

_____ **Adverse reactions to prescribed medications should be reported to the office, which may result in change in dosage or discontinuation of medication.**

These risks are much higher and more severe if controlled substances are used together with other narcotics, alcohol, marijuana, cocaine, stimulants, depressants, hallucinogens, or mood-altering drugs.

_____ **I agree to abstain from any illegal or legal medications not prescribed to me (narcotics, marijuana, stimulants, depressants, hallucinogens, or mood-altering drugs) while taking this medication.** The use of cannabis products (including smoking or edibles) is prohibited even where legally allowed. Topical CBD ointments, oils, lotions, and creams are allowed.

_____ **I agree not to consume alcohol while taking this medication if my prescriber deems it important. (Prescriber must initial one:)**

_____ NO alcohol allowed.

_____ Alcohol may be consumed within reasonable parameters:

No more than ____ standard drinks per

day | week | occasion.

_____ **I agree to obtain my controlled substance prescription from providers at PSFM only.**

_____ **I will communicate with other providers who are treating me that I am under a controlled substance agreement with the prescribing provider.**

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_____ **I agree to follow up with recommended consultations, laboratory studies, imaging studies, and/or non-medication therapies as directed by my provider. These studies may include a blood and/or urine drug test done on a random basis at the discretion of your provider.**

_____ **If I am prescribed a narcotic pain reliever prescription by any other provider including Emergency Department provider due to an acute injury, I will call PSFM the same day or next business day to notify the office.**

_____ **If I am prescribed a narcotic pain reliever prior to a planned procedure (such as for a knee replacement), I will call PSFM the same day or next business day to notify the office.**

_____ **I consent to release this agreement information to other providers, emergency departments, pharmacies, and consultants and to allow pharmacies to release my prescription history. I also consent for other providers, emergency departments, pharmacies, and consultants to report violations of this agreement to the prescribing provider and my primary care provider.**

_____ **I understand that I can reduce the use of medications by leading a healthy lifestyle and will work with my provider to optimize my overall health.** This may include regular exercise, diet changes, quitting smoking and other lifestyle modifications.

_____ **The terms of this agreement will end with the termination of controlled substances by the prescribing provider, and this may include medications other than those listed on this form.**

_____ **I have read and discussed with the prescribing physician the above agreement and terms for use of controlled substances medications as they pertain to my care. All of my questions about controlled substance medication use and the policies of this practice have been answered to my full satisfaction.**

_____ **I understand and agree to the following policies of Princeton Sports and Family Medicine regarding the use of controlled substance medications**

Patient signature _____ **Date**_____

Provider signature _____ **Date**_____