



101 Pilgrim Village Dr #400

Cumming, GA 30040

PH 770.441.4824

FX 770.441.4826

### **Controlled Substance Patient Agreement**

#### **I will:**

- Get my pain/ADHD/controlled substance medication only from Dr. Kelley Stahl.
- Take my medication as this doctor has ordered.
- Tell this doctor about all my health problems. This is more than just why I need this medication.
- Tell this doctor about all my other medications. This includes prescriptions from other doctors as well as over-the-counter and herbal medications I decide to take.
- Tell this doctor if I go to the Emergency Room and get more of this type of medication there.
- Tell my other doctors about all medications I take.
- Allow this doctor, or any other, to test my blood and urine. This is to confirm that I am taking only my prescribed medication and nothing more or less.

#### **I will not:**

- Change how I take my pain/ADHD/controlled substance medication without first talking with this doctor.
- Share, sell or trade my medication.
- Use illegal drugs.

#### **When I refill my pain/ADHD/controlled substance medication prescription, I will:**

- NOT ask for early refills, even if I lose or misplace my medication- unless previously discussed with this doctor and a change in dosing has been mutually agreed upon.
- Follow my doctor's refill policy     1. Minimum every 3 month office visits. 2. If a dose change has been made I will follow up in 2-4 weeks to reevaluate the dosing.

#### **I know that:**

- Pain/ADHD/controlled substance medications can be addictive. This means that my body may need more and more medication or that it can be hard to stop taking this medication.

- Pain medication treats my pain but not its causes.
- ADHD medication treats my symptoms of attention deficit disorder but does not cure it.
- I recognize that short acting Antianxiety/sleep medications are not recommended for chronic or long term use. In certain circumstances exceptions are made, but I will agree to work with my doctor to find alternatives as tolerated.
- I recognize that narcotic use for chronic pain is not a standard recommendation outside of cancer treatment. In certain circumstances, exceptions are made, but I will agree to work my doctor to maintain the lowest dosage necessary to control my pain and to try alternative methods of managing pain as recommended by my doctor.
- I may need other medication and tests to diagnose and treat my health problems.
- Pain/ADHD/controlled substance medications can cause side effects. It may cause me to be sleepy or slow my reflexes (how I respond or think). These side effects can make it unsafe to drive a car or use machines.

**My agreement:**

This doctor and I talked about my pain/ADHD/controlled substance medication. I understand that I must follow this agreement. If not, this doctor will not prescribe pain/ADHD/controlled substance medication for me. This doctor may refuse to provide these medications if I do not follow this agreement.

Patient

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

Signature: \_\_\_\_\_

—

Doctor

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

Doctor

Signature: \_\_\_\_\_

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

—