APPENDIX 3: Sample Treatment Agreement

Treatment Agreement

This treatment agreement ("contract") describes the responsibilities and rules for the prescription of certain drugs by the physician(s) in this facility.

This agreement is between ________________________________ and Dr. _____________________________
(Patient name) (Physician name)
and applies to the following medications ("*contract drugs*"):

"-all narcotics, tranquilizers, sedatives and sleeping pills

"-the following medication(s): ____

1. **Dr. _____________________________ will be the only doctor to prescribe these contract drugs for me.**

2. When Dr. ________________________________ is away, he/she will make sure that there is another doctor in this clinic to prescribe my contract drugs.

3. I cannot renew or refill my contract drugs after hours.

4. I will pick up my medication from only one pharmacy, and have chosen this pharmacy:

________________________________ at _____________________________ [_____-________-_______]
(Pharmacy name) (Pharmacy location) (Phone)

5. I understand that this medication can be dangerous and that it is meant only for me.
- I will not use my medication more often or at higher doses than prescribed.
- I will not give, lend, or sell my medication to anyone.

6. I will not be given a new prescription if my medication is lost or stolen.

7. I understand that my medication may be very dangerous if mixed with illicit drugs or alcohol. For my safety, I may have to provide a urine sample for drug testing from time to time. I understand that my doctor may decide to stop prescribing my contract drugs if I am using any unauthorized drugs.

8. My doctor needs to safely monitor my care. Unless there is a life-or-death emergency, I will see Dr. _______________________ before seeing any other doctor. If I need help after office hours, I will call the doctor on call.

9. I will tell Dr. ________________________ if I see any other doctor, including specialists and doctors at the Emergency Department.

10. I understand that there is a risk that I will become addicted to the contract drugs. I have discussed other treatment choices with my doctor.

11. I understand that if I do not follow the terms of this agreement, my doctor may decide to stop prescribing some or all of my medications.

_______________________________ _________________________ _______________
(Patient signature) (Witness) (Date)

"-copy to chart "-copy to patient "-copy to _______________