Proposed medication(s): ________________________________

Primary Care Provider: ________________________________

- Narcotics will be prescribed by your primary care provider and during his or her absence by the covering provider.
- A 30 day supply of medications will be prescribed at a time.
- All prescriptions must be filled at the VA Pharmacy and the pharmacy will receive a copy of this document.
- Medications will not be replaced if they are lost, stolen, got wet, left them on the bus etc. If medications have been stolen and you complete a police report regarding the theft, an exception may be made.
- No increases in medications are allowed without the approval of your primary care provider. No prescriptions will be refilled early due to your independently deciding you need more medication than is prescribed. **Self-increases of medication dose or frequency are not allowed.**
- Unannounced urine toxicology screen maybe requested and your co-operation is required. Presence of unauthorized substances may prompt referral for assessment for addictive behavior.
- All patients are expected to fully follow their individual treatment recommendations.
- In the event we discover you are receiving narcotic medications from any other clinics or physician(s), you will not receive any further refills – the only exception being short-term prescription of a narcotic medication in the event of injury, or short-term prescription for a dental or surgical procedure.

**CAUTION:** Narcotic medication may cause drowsiness. Alcohol should not be consumed while taking these medications. Use care when operating a car or dangerous machinery. Federal law prohibits the transfer to any other person other than the patient for whom they were prescribed.

*I, the undersigned, have had the above guidelines explained to my satisfaction and all of my questions and concerns about medications and my responsibilities have been addressed. I agree to comply with the above guidelines. I have received a copy of this document.*

Patient: ___________________________ ___________________________ ___________________________

Witness: ___________________________ ___________________________ ___________________________

  Printed Name                          Signature                          Date

7/2004