



## Cornerstone Psychiatric Services, Inc.

David Donahue, D.O.    David Fawks, APRN    Nina Kirchgessner, APRN

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### CONTROLLED SUBSTANCE AGREEMENT – Page 1 of 2

The purpose of this contract is to establish an agreement between the clinician and patient on conditions for prescribing and use of controlled substances in the event use of these agents is deemed medically appropriate. This agreement is essential in maintaining the trust and confidence necessary in the clinician/patient relationship. Should controlled medication be a part of your treatment, the frequency and type of medication prescribed is, and must be, under the discretion of your prescribing clinician: David Donahue, D.O., David Fawks, APRN or Nina Kirchgessner, APRN.

Your treatment may require the use of controlled substances which may include, but not limited to, hypnotosedatives or stimulants. The use of controlled substances carries several risks, such as physical dependency, when used on an extended daily basis. **Side effects from hypnotosedatives and stimulants** include, but are not limited to, drowsiness, fatigue, impaired coordination, irritability, memory impairment, lightheadedness, dizziness, sexual difficulties, depression, confusion, weakness, constipation, changes in appetite or weight, palpitations, increased heart rate and /or blood pressure, psychotic episodes, restlessness, overstimulation, insomnia, euphoria, tremor, exacerbation of tics, dry mouth or possible worsening of clinical psychiatric condition. Taking more controlled substances than as prescribed and/or combining controlled medications with other medications, illicit substances or alcohol could result in life-threatening conditions including but not limited to respiratory failure, cardiac failure, coma, organ damage or even death. Another serious problem associated with prescribing controlled medications is the diversion of controlled substances for resale. Diversion is defined as use of prescription medications for nonmedical recreational or illicit purposes.

**Withdrawal symptoms from hypnotosedatives** may include, but are not limited to: insomnia, muscle cramping, vomiting, sweating, tremors, convulsions or death. **Withdrawal symptoms from stimulants** may include, but are not limited to: depression, intense fatigue and sleepiness.

Tolerance can occur with these medications and is defined as requiring increasing doses of the medication to obtain the same effect. Tolerance is differentiated from addiction. Addiction involves abnormal social behavior to obtain controlled substances such as stealing, lying or abusing the medications that have been prescribed. Addiction is not typical in patients who do not have a prior history of addiction to controlled substances, alcohol or illicit substances.

The rules of this agreement may seem extremely strict and demanding. These rules are intended to protect you and others from the improper use of controlled substances. Your clinician believes that these rules are fair and necessary. Your understanding of these liabilities is important and appreciated by all your health care professionals. This agreement must be signed and returned upon your initial visit or signed at the request of your clinician or staff at Cornerstone Psychiatric Services. You may request a copy of this agreement at any time.



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## CONTROLLED SUBSTANCE AGREEMENT – Page 2 of 2

By signing this form, I have read, understand and agree to the following:

- All controlled substances will be taken only as prescribed.
- That I have been informed of the risks and side effects of controlled substances.
- To be seen and evaluated at least every 3 months to assess the efficacy and appropriateness of treatment.
- All controlled substances will only be prescribed for 30 day supply.
- To contact your clinician to seek approval should I feel my medications should be altered in any way other than prescribed.
- Not to increase dosage of my controlled medication unless authorized by your prescribing clinician or on-call clinician.
- To exercise caution when performing activities, such as driving or operating heavy machinery.
- Not to use any illegal substances, including marijuana, cocaine, etc.
- Not to use the medication with any alcoholic beverages.
- Not to share, sell or trade my medication for any reason, including money, goods or services.
- Not to attempt to obtain controlled substances from any other health care provider without disclosing the current medications prescribed by Dr. Donahue, David Fawks, APRN and/or Nina Kirchgessner, APRN.
- To bring any remaining controlled substances in their proper containers at the request of your clinician or staff. These medications may be counted by any of the Cornerstone Psychiatric staff.
- It is my responsibility to protect and secure any controlled medications prescribed to me, which may not be replaced if lost or stolen.
- To obtain all my controlled medications from only one pharmacy (**Pharmacy name:** \_\_\_\_\_).
- To notify Cornerstone Psychiatric office immediately should I change pharmacies and to furnish my new pharmacy with the address and telephone number of my old pharmacy.
- Your clinician or designated staff at Cornerstone will access and obtain Controlled Substance medication(s) history through the use of the State of Florida Prescription Drug Monitoring Program, E-FORCSE or any other PDMP system.
- To authorize Cornerstone Psychiatric and my pharmacy to fully cooperate with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my controlled substance(s).
- To authorize Cornerstone Psychiatric to provide a copy of this agreement to my pharmacy.
- To submit a blood or urine test, at random, if requested by any Cornerstone Psychiatric clinician to determine my compliance with this contract.
- Failure to comply with this contract may result in the withdrawal of all controlled substances, which may result in referral to a detoxification and substance treatment program, as well as termination of the clinician/patient relationship.
- I agree to release Dr. Donahue, David Fawks, APRN, Nina Kirchgessner, APRN and the staff at Cornerstone Psychiatric Services, Inc., from all responsibilities and obligations of the clinician/patient relationship should I breach this contract and I understand I will be terminated as a patient of Cornerstone Psychiatric.

I have read, fully understand and agree to comply with this contract.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Witness Name (please print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date