

## HOSPITAL/CLINIC MEDICATION SAFETY AGREEMENT AND INFORMED CONSENT FOR TREATMENT

My Indian Health Service provider, \_\_\_\_\_, has prescribed \_\_\_\_\_ to treat my \_\_\_\_\_ (condition). This medicine has potential for dependence, misuse, harm and addiction.. This agreement is to outline our understanding of our roles and responsibilities regarding this medicine.

We here at <<>> are making a commitment to work with you in your efforts to improve your overall function and wellness. To help you in this work, we agree:

1. We will treat you with courtesy and respect. This includes making sure we discuss all medication concerns in private. We do not give out information about your medication without consent.
2. We will work with you to create a pain treatment plan that includes regular appointments for follow-up visits and medication refills. If we have to cancel or change your appointment, we will make sure you have enough medicine to last until your next appointment. Otherwise medications will only be filled on schedule.
3. We have a Medication Safety Committee made up of providers, pharmacists, physical therapists, and social workers. This committee reviews all decisions about starting, continuing, or stopping these medications.
4. We will take the time to make sure you understand how to safely take your medication.
5. We will provide these medications in 7-28 day supplies, always due on the same day of the week.
6. We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
7. We will keep track of your prescription fills and test for drug use regularly.
8. We will suggest and refer you for other forms of treatment to help with your condition. We will work with you to set treatment goals and monitor your progress toward those goals.
9. We will provide clear instructions about how to contact your primary care team to discuss side effects, dosage change, or to report other prescriptions.
10. If we stop these medications because you have not followed this agreement we will:
  - a. Explain to you why your medications are being stopped
  - b. Continue to treat you and help you with your chronic condition in other ways.
  - c. Treat you with the best medications in an emergency or for another problem.
11. If you become addicted to these medications, we will help you get treatment and safely get off the medications that are causing you problems.

I understand that:

1. This medicine will not cure my problem. It only treats symptoms.
  - a. I will do other tests and treatments for my problem as recommended by my provider. This may include things like counseling, physical therapy, exercise, injections, surgery and other medications.
  - b. I will work with my provider to improve my other health conditions such as diabetes, depression, high blood pressure, etc. Improving my health will often make pain, sleep and mood better.
  - c. I will schedule and keep my appointments with my provider. If I do not consistently maintain my appointments with my provider my medicine will be stopped.
  - d. If this medicine does not work to improve my symptoms or help me do the things I need to do better, it will be stopped and we will try other treatments.

2. This medicine has powerful effects on the brain that can lead to addiction, illness, injury or death if not used as prescribed.
  - a. I will take my medication as prescribed. I will not take extra doses or stop this medication without talking to my primary care team first.
  - b. I will not use any federally illegal drugs including marijuana, heroin, methamphetamines or cocaine while taking this drug.
  - c. I will not take anyone else's prescription medication.
  - d. I understand that I should not mix this drug with alcohol or other drugs as I may not be able to think clearly and I could risk personal injury.
  - e. I will give blood or urine samples to test for drugs whenever requested by my provider. If I refuse to give a sample, give a sample that is not mine, leave before giving a sample, or if illegal drugs show up in my system, my medication may be stopped.
  - f. I will bring in my unused medication for a pill count as requested by my primary care team.
  - g. I will not drive or operate machinery if my medicine makes me sleepy.
  - h. I will not get any opioid medicines or other medicines that can be addictive, such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamines) without telling a member of my health care team before filling the prescription. I understand the only exception to this is if I need a pain medication for an emergency at night or on the weekends, or if I have surgery. I will notify my primary care team about these situations as soon as possible.
  - i. If a report from the State of MN Prescription Monitoring Program shows I am getting medications I did not tell my provider about, my prescription may be stopped.
3. This medicine is one that is often illegally bought and sold in our community (diverted). Medicines that are diverted lead to addiction, crime, suffering, and death, especially among our youth.
  - a. I will not sell, trade or share this medication with anyone else. I understand that if I do, my medication will be stopped.
  - b. I will keep my medicine safe, secure and out of the reach of children. If my medicine is lost or stolen it will not be replaced.
  - c. If my blood or urine samples do not show the prescribed medicine in my system, this medicine may be stopped.
  - d. If I treat IHS personnel disrespectfully with regard to my prescriptions this medicine may be stopped and my access to the facility may be restricted.

By signing this Medication Safety Agreement and Informed Consent for Treatment, I agree to abide by the terms of this agreement.

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*Patient signature*

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*Provider/Case Manager signature*

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*Date*