Patient Name: _____

Student #: _____

D.O.B.: _____

Cornell Health Controlled Medication Agreement

The purpose of this contract is to help prevent misunderstandings about certain government-controlled medications that you will be taking. This will help you and your health care provider comply with state and federal laws regarding controlled medications.

- I understand that all prescriptions for controlled medications must come from the provider whose signature is below or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception.
- I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulants or anti-anxiety medicines, from any other provider. In the event that I develop a serious acute medical condition that another health care provider, such as an Emergency Department staff member, treats by changing any controlled medication, I will notify my Cornell Health provider immediately of any changes.
- I will request renewals of my controlled medications during my appointment with my medication provider. Requests for renewals at other times may not be granted.
- If I do not keep my appointment and call in for a refill, only a limited supply of medication will be ordered until a follow up appointment.
- If I request a refill of my controlled medication outside of my appointment time I will do so during weekday business hours, 8:30am – 4:30pm (Monday through Friday). Additionally, I will give Cornell Health at least 48 hours (two (2) business days) notice for these renewals. If I do not give this notice, I understand that my prescription renewal may be delayed.
- Early renewals (renewals prior to the date the prescription was to run out) will not be given.
- Renewals will be based on my keeping scheduled appointments at a frequency determined by my provider.
- I will not consume excess amounts of alcohol, nor will I use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication with anyone.
- I will not adjust the dose or amount of controlled medications I take without first discussing and obtaining approval from my health care provider.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will safeguard my medicine from loss or theft. Lost, damaged or stolen medicines will not be replaced.
- I agree that I will submit to an unannounced blood or urine test periodically as requested by any health care provider to determine my compliance with my program of controlled medicine use. Abnormal test results would be grounds for discontinuation of the prescribed medication. Refusal of such testing may also subject me to an immediate tapering/discontinuation of my medication.

- The Cornell Health provider prescribing my medication has permission to discuss all diagnostic and treatment details with dispensing pharmacists and/or other professionals providing my health care.
- I understand that my Cornell Health provider and my pharmacy will cooperate fully with any city, state or federal law enforcement agency, including New York State's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize Cornell Health to provide a copy of this Agreement to my pharmacy, other health care providers, emergency departments, and insurance carriers, as necessary.
- I understand that if I break this agreement, my care provider will stop prescribing these controlled medicines for me. In this case, my health care provider may taper me off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms.
- I have thoroughly read this agreement and any questions that I have concerning the agreement has been answered to my satisfaction by my provider.

Patient Signature: _____ Date: ____/____/____