Tabitha Hospice Controlled Substances Agreement

The purpose of this agreement is to protect you and your caregiver(s) in managing controlled substances prescribed to you while under the care of Tabitha Hospice. Because these drugs have the potential for abuse or diversion, strict accountability is necessary.

1. All controlled substances must be prescribed by your physician or physician partner, or the Hospice Medical Director.
2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications you take.
3. You may not share, sell or otherwise permit others to have access to these medications.
4. These drugs should not be stopped abruptly.
5. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medications and prescriptions. They should not be left where others might see or otherwise have access to them.
6. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of the reach of such people.
7. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due.
8. If the responsible legal authorities have questions concerning your treatment—for example, if you were obtaining medications at several pharmacies—all confidentiality may be deemed waived and these authorities may be given full access to records of controlled substances administration.
9. It is understood that failure to adhere to this agreement may result in discharge from Tabitha Hospice.
10. It is recommended that any unused medications should be disposed of according to the Disposal of Medications form provided on admission.
11. The risks and potential benefits of these medications have been explained and you acknowledge that you have received such explanation.
12. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

Patient Signature ________________________________ **Date** ____________

If patient is unable to sign, please document reason ________________________________

Caregiver Signature ________________________________ **Date** ____________