Ormond
Family Care

Savitha B. Kasturi, D.O., P.A.
Board Certified in Family Practice

CONTROLLED DRUG AGREEMENT

A. I am aware that *if* a physician from **Ormond Family Care** prescribes a narcotic analgesic to lessen the pain for my condition, or any controlled drug, the medication has certain risks associated with it.
B. These risks may include, but are not limited to, sleepiness, drowsiness, constipation, nausea, vomiting, dizziness, itching, allergic reaction, slowing of respiratory rate, slowing of reflexes and reaction time, physical addiction and dependence, and addiction. This medication may lessen the pain but not provide complete pain relief.
C. The physician will discuss other forms of treatment that do not utilize the prescribing of narcotic analgesics or controlled drugs. I understand that signing this form does not imply that the doctor will prescribe a controlled substance.
D. **In accepting the prescription for controlled medication/s I agree to the following:**

I will not solicit or accept any controlled medication from any other health care professional.

I will make the doctor aware of all other medications that I take.

I am aware of the possible side effects and risks of these medications and will have all recommended laboratory studies.

I am aware of the policy of random drug screen urine testing and agree not to refuse any random drug screening. Patients will be responsible for the payment of the drug screens.

I will not use any illegal or illicit substances including, but not limited to, marijuana, cocaine, etc.

I will not share or sell my medication.

I will not operate heavy machinery or drive a motor vehicle while under the influence of these medications.

I understand that I am responsible for my medication. The medication is prescribed in a 30-day supply. It will not be replaced or filled early for any reason.

I understand that I must be seen by the prescribing physician every 30 days to have my condition evaluated before being issued any controlled medication renewals.

I understand that in no case will any controlled medication be renewed over the telephone or by any other electronic forms of communication.

I understand that if I do not agree to, and follow, these rules of **Ormond Family Care** concerning controlled prescriptions that I can be discharged from the care of the doctor.

Patient/Legal Representative Signature	Date	Patient Name (PRINT)	Date

279 S. Yonge Street - Ormond Beach, FL 32174
Phone (386)944- 9704 - Fax (386)947-7951