Yukon

REFERRED CARE CLINIC

YUKON MEDICATION AGREEMENT

Referred Care Clinic - Yukon
210 Elliott Street
Box 2703 – H-2RCC, Whitehorse, YT, Y1A 2C6
Telephone: (867) 668-2552 • Fax: (867) 668-2565

{affix patient demographic label here}

I _____ understand that I am receiving controlled medication(s) from: _____ Referred Care Clinic-Yukon **Physician** and/or Referred Care Clinic-Yukon **Nurse Practitioner.**

Controlled medications are medications that need to be carefully prescribed and monitored, because they have potential to cause harm or even death by misuse or addiction.

My responsibility as a patient:

I understand and agree to the following conditions under which this medication(s) is prescribed.

1. Only the above healthcare professional(s) will prescribe controlled medications for me. I will not seek controlled medications from any other prescriber.
2. I will not take controlled medications in larger amounts or more frequently than prescribed by the above healthcare professional(s).
3. I will not give or sell my medications to anyone else, including family members. I will not accept controlled medications from anyone else.
4. I will not use over-the-counter (OTC) opioid or controlled medications, for example, 222s or Tylenol Nº 1, etc…
5. I understand that if my prescription runs out early for any reason (e.g., losing the medication, taking more medicine than prescribed, etc.), the above healthcare professional(s) will not prescribe extra medication for me. I will have to wait until my prescription is due to be refilled.
6. I will fill all prescriptions only at one drugstore: _____ NAME OF PHARMACY
7. I will always store my medication in a secure location.
8. I consent to participate in random, possibly witnessed urine drug screening as needed for the purpose of monitoring and safe prescribing of controlled medications, and provide a sample within 24 hours of request.
9. I consent to bring medications to the clinic on request for random pill counts as needed.
10. I am aware that serious, life-threatening, or fatal respiratory depression (stop breathing) may occur with use of these medications, especially when starting it or increasing the dose. Using these medications in a way they are not prescribed, such as chewing, snorting, or injecting, may result in uncontrolled release of the medications and put me at risk for overdose and death. Combining these medications with alcohol or taking several medications that cause respiratory depression (including opioids and benzodiazepines) also puts me at risk for overdose and death.

My Healthcare Provider's Responsibilities:

As your provider, I agree to perform regular checks to assess how the medication is working. I Agree to review your complete medication profile so that I can prescribe safely and monitor for Interactions. I agree to provide primary care even if a controlled medication is discontinued.

I understand that if I do not comply with these conditions, it may compromise my safety, and the Referred Care Clinic – Yukon health providers will discuss and make changes to my medications to ensure clinical safety, which may include discontinuing, reducing or modifying my controlled medications. This agreement is valid for the duration of my care at the Referred Care Clinic – Yukon.

Patient Signature: _____ Date: YYYY/MM/DD

Healthcare Professional Signature: _____ Date: YYYY/MM/DD