JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being
Mental Health Services

CONTROLLED SUBSTANCES AGREEMENT

Client name:_____ **Today's date:** ____/____/_____

Client DOB: ____/____/_____ **Client phone:**_____

Client address: _____

Medication(s) included in this agreement:

I understand that:

1. My provider is prescribing me the medication(s) above to treat a diagnosed condition or symptoms.
2. This medication has a risk of misuse, abuse, and addiction, so it can only be prescribed if certain terms are met.
3. It is the shared responsibility of client and provider to review and practice safe use of controlled substance medication, and to take appropriate steps to decrease the risk of diversion, misuse, and abuse.

I have discussed the following with my provider and agree/acknowledge that:

1. I will only take my medication as prescribed.
2. I will not give, sell, trade, or share this medication.
3. I will keep my medication in a safe place, such as a locked storage compartment.
4. New prescriptions will not to be written earlier than 25 days from previous date.
5. Deviation from my prescriber's recommended plan for follow up appointments may result in a delay in receiving my prescription.
6. I understand that use of cannabis, alcohol, and/or other illicit/recreational substances can interact with my medication treatment and compromise its effectiveness. If my provider has concerns this is impacting my treatment, they may request a toxicology screen as condition of receiving ongoing care.
7. Lost and stolen medicines cannot and will not be replaced.
8. I will not get medicines or prescriptions from other providers without telling my SHWB prescriber (except in case of emergency).
9. I will only use one pharmacy for filling my prescriptions.
10. I agree to weight and blood pressure checks via JHU SHWB at my prescriber's recommended schedule.
11. Suspicion or evidence of prescription diversion, misuse, or abuse is grounds for discontinuation of medicine without consideration of future prescribing.
12. I am not able to receive a prescription for a controlled substance when I am outside of Maryland/DC, including during breaks in the academic calendar. I am responsible for arranging for my prescription to be refilled during breaks as needed and will communicate my plan with my JHU SHWB provider ahead of time.

Client signature: _____ **Date:** _____

Provider signature: _____ **Date:** _____