WELLSPAN HEALTH

☐ The Chambersburg Hospital
☐ Ephrata Community Hospital
☐ The Gettysburg Hospital
☐ The Good Samaritan Hospital of Lebanon
☐ Philhaven
☐ Waynesboro Hospital
☐ WellSpan Medical Group
☐ WellSpan Surgery and Rehabilitation Hospital
☐ York Hospital

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

CONTROLLED SUBSTANCE AGREEMENT (CSA) WELLSPAN HEALTH

Date CSA should be discussed again (1 year from signing): _____

Does the patient have a CSA with another prescriber? If so, with whom? _____

These medications are controlled by special state and federal laws because of their risk of abuse and/or addiction. They include opioid (narcotic) pain medications, ADHD medications, anxiety medications, and medications to help with sleep.

To ensure health and safety for you and the community, WellSpan Health and you should agree to the following before controlled medications are prescribed to you. Not following this CSA may result in WellSpan Health not being able to prescribe your controlled medications to you because of safety concerns.

Education provided on (check): ☐ Opioid Medication ☐ Stimulant Medication ☐ Benzodiazepine ☐ Other: _____

AS THE PATIENT I AGREE TO:

- Get my controlled medications from this office only. If I get ANY controlled medications from anywhere else, I will contact this office the next business day
- Tell other health care providers about this Controlled Substance Agreement, including emergency departments and urgent care centers
- Not miss required appointments
- Use other treatments that may be recommended
- Request refills only during office hours and at least 2 business days before I run out
- Use medicine as prescribed, and I will not request early refills
- Keep medications in a secure place, out of the reach of children. I understand lost or stolen medications will not be replaced
- Not share this medication with or sell it to anyone
- Not take street drugs or any form of marijuana without approval
- Pill counts and urine drug screens when requested, even if I must pay for the tests
- Treat my treatment team with dignity and respect

I read (or have had read to me) and agree to the above:

_____
Patient/Responsible Party Signature

_____
Name (Print)

_____
Relationship to Patient

_____ _____
Date Time

AS THE MEDICAL OFFICE WE AGREE TO:

- Protect the privacy of your medical information as required by law. We may share information, such as the use, or concern for misuse, of controlled medications with other health care providers
- Do our best to help you function better, even if we need to decrease or stop your controlled medications
- Be aware of medical guidelines when prescribing
- Help you avoid side effects, misuse, abuse, and addiction
- Work with you to decrease your controlled medicine if the risk of the medicine is more than the help you get from it
- Tell you if we are concerned about controlled medication misuse, and if needed, we will help you heal from addiction
- By law, report to the Department of Transportation, if we believe the medications are affecting your ability to drive safely
- Follow state and federal laws, like checking computer records when prescribing controlled medications
- Always treat you with dignity and respect as a partner in your care

I agree to hold my office to the above:

_____
Physician/APC Signature

_____
Name (Print)

_____
Practice

_____ _____
Date Time

Form #11620 Rev. (09/22)
Controlled Substance Agreement
WCSA0001