

Treatment Contract

for the use of a Schedule 8 medicine

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_

Address: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Medicine(s) name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_ **PLEASE COMPLETE ALL DETAILS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that a Schedule 8 medicine including that listed above is to be prescribed to me in an attempt to improve my level of functioning. My medical practitioner and I have discussed that this medicine may only be partially helpful in achieving this goal and on occasion will not help at all. I understand that this medicine is only one part of the management of my condition. My medical practitioner and I agree to the following conditions regarding my treatment and for the prescribing for my condition:

1. My medical practitioner is responsible for prescribing a safe and effective dose of my medication. I will not use my medication other than at the dose prescribed and I will discuss any changes in my dose with my medical practitioner.
2. I am responsible for the security of my medication. Lost, misplaced or stolen medicines or prescriptions will not be replaced.
3. I will only obtain my medication from the medical practitioner who signs this contract, or other doctors in the same practice authorised to prescribe to me. I understand that no early prescriptions will be provided.
4. Whilst most people do not have any serious problems with this type of medicine when used as directed, there can be side effects. My medical practitioner has explained the main ones to me, and I will tell him or her if I experience what could be side effects.
5. I am aware that my medical practitioner may be required to gain authorisation from the Department of Health for continued prescription of my medication.
6. As dependence is possible during the management of my condition, I have informed my medical practitioner of any present or past dependence on alcohol or drugs that I may have had, and of any illegal activity related to any drugs (including prescription medicines) that I may have been involved in.
7. I am aware that providing my medication to other people is illegal and could be dangerous to them.
8. My medical practitioner respects my right to participate in decisions about my condition and will explain the risks, benefits and side effects of any treatment.
9. My medical practitioner and I will work together to improve my level of functioning.
10. I understand that my medical practitioner may stop prescribing my medication or change the treatment plan if my level of activity has not improved, if I do not show signs of improvement, or if I fail to comply with any of the conditions listed above.

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical practitioner’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical practitioner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical practitioner’s provider number: \_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide a copy of the signed contract to the patient.**

## Why do I need to sign a treatment contract?

Both you and your doctor are subject to strict regulations when certain Schedule 8 medicines are prescribed. A treatment contract is used so that your doctor is sure that you understand what is expected from you whilst you take this type of medicine, and that you consent to the requirements described in this contract.

There needs to be trust, honesty and good communication between you and your doctor when a Schedule 8 medicine is prescribed.

The doctor who prescribes you a Schedule 8 medicine is expected to:

* do his or her best to prescribe the medicine safely and effectively
* arrange your appointments and prescriptions so that you do not run out of your medication.

In order to receive these Schedule 8 medicines, it is normal to sign a treatment contract with your doctor. This will list some important conditions you will need to accept. Some of the things expected of you are:

* Agree to get all of your prescriptions for your Schedule 8 medicine(s) from one doctor only. This may be a specialist doctor or your General Practitioner (GP). You should fill all your prescriptions at the same pharmacy.
* Agree to take the medicine only as prescribed and not to change the dose.
* If you are travelling away from home for long periods of time, you will need to discuss your medication requirements with your doctor so arrangements can be made if ongoing supply is required.
* If you have ever been dependent on alcohol or other drugs (including prescription medicines) you need to tell your doctor **before** signing the contract. A past problem of this nature does not mean that you cannot have a Schedule 8 medicine for your condition; however it does mean that you could be at risk of developing another drug problem and your doctor needs to know this. Past problems you must tell your doctor about include any illegal activity involving drugs.