**Controlled/ Addictive drugs patient agreement**

**Do you take drugs of addiction or drugs which could potentially cause significant harm?**

**i.e. Morphine, Tramadol, Gabapentin Diazepam, Tamazepam**

**Please note the above list of drugs is not exhaustive**

**Yes No**

**If no please sign ……………………………………………………………. Date……………………**

 **Print name…………………………………………………………………………………………..**

**If yes please read and sign below**

The Surgery clinicians will only prescribe these drugs on a needs basis and your use will be regularly reviewed.

If you declare that you are using controlled drugs please be aware that we have a strictly adhered to policy in respect of the prescribing of controlled drugs.

If you state you are taking any controlled drugs you will be seen by a GP.

 At this meeting you will be informed that as a patient of this practice you will be expected to attend regular appointments and where possible you will be weaned off these prescription drugs.

 Any prescriptions issued during this period will be prescribed strictly on a weekly basis for you to collect in person.

It will be your choice as to whether you accept this agreement or choose to register with another GP practice.

If you do not declare on registration that you are taking controlled drugs and then ask for a prescription you will be removed from the patient list and advised to register with another GP practice. There are no exceptions to this rule.

Please sign below that you understand and are willing to comply with this agreement

Print Name ……………………………………………………………………..

Signature ………………………………………………………………………..

Date …………………………………………………………………………………