(For use when patients are prescribed medicines which may potentially be misused or diverted. These may include but are not restricted to: S8 substances, benzodiazepines, anabolic steroids, pseudoephedrine, medicines listed as ‘monitored medicines’ by Regulation 81C of the Medicines, Poisons and Therapeutic Goods Act Regulations 2014)

I (patient full name).......................................….................…………………Date of Birth........../.…....../...........

of (residential address).......................................................................................................................................

Medicare Number ..................................…..Concession Card Number.............................................................

agree to the following conditions during my treatment with prescriber .............................................(prescriber name)

**Medicine details:** Drug name, dose & instructions (do not use the phrases mdu/prn)

............................................................................................................................................................................

**Pharmacy to dispense** (name, phone no)........................................................................................................

**Frequency of collection** from pharmacy (daily, weekly, etc)...............................................................................

**Conditions:** This agreement is valid from ……….../........./............ until ..…......./….…..../............

I agree to see only the above prescriber / practice and pharmacy for my treatment.

I have informed my prescriber of any history of substance dependence or misuse. I understand that my medication can interact with other substances, especially sedatives. Therefore, I will inform my prescriber of any other medicine or drugs I am taking - both legal and illegal. Undisclosed drug use, diversion, selling or illegal activities may result in termination of this agreement.

I agree that my prescriber may contact Services Australia (who administer the Pharmaceutical Benefits Scheme), NT Health Medicines and Poisons unit regarding which medicines I have been prescribed by other health practitioners.

I agree that my prescriber may also advise other prescribers, pharmacists and Alcohol and Other Drugs Services of the medicines I have been prescribed.

I understand that my medicines may cause dependence. The risks of dependence, tolerance and side effects such as cognitive impairment (confused thinking) due to the medicine have been explained to me.

I understand that no replacement or early prescriptions for my medicine/s will be provided to me. Looking after medicines and scripts is my responsibility.

I agree to take the medicine as prescribed by my prescriber and understand that if I do not, my treatment with this medicine may be reduced or ceased.

I agree to attend my booked appointments for medical review and if I do not attend, my treatment with this medicine may be reduced or ceased.

I understand that the prescribed medication is only part of my overall treatment plan and agree to pursue other appropriate management measures as discussed with my doctor.

I understand that abusive, violent or threatening behaviour towards health staff, or other patients will not be tolerated and will result in termination of this agreement.

**I understand that if I can no longer meet the conditions of this agreement, my treatment may be changed or ceased by my doctor.**

I have read this agreement and understand it.

Signed (patient signature):......................................... Health Practitioner/Witness:...................................…….