

St. Clair County Community Mental Health Authority
Benzodiazepines Requirement Agreement

Benzodiazepine-type drugs include: Xanax, Ativan, Klonopin, Valium, Librium, Restoril, Dalmane, Ambien, Lunesta, etc. These drugs have abuse potential. The following requirements are needed to be agreed upon by the person receiving the prescription for any of these medications.

Participant's Name: _____ Date: _____

An individual who wishes to receive a prescription for any benzodiazepines, freely and voluntarily agrees to accept the following agreements:

1. I agree to keep and be on time to all of my scheduled appointments.
2. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my prescription is a serious violation of this agreement and will result in my medication prescription being terminated. I am aware that I will at random be required to submit to a pill count and urine drug screen periodically.
3. I agree that my prescription will be prescribed at my scheduled visits with my CMH prescriber. Missing appointments can subject me to a drug withdrawal reaction.
4. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
5. I will not leave my medication in a public part of my home, leave the bottle open or near water or children. I am aware that these medications can be very dangerous to children.
6. I agree not to obtain controlled substance prescriptions from any doctors, pharmacies or other sources without informing CMH prescriber.
7. I understand that mixing benzodiazepines with alcohol, narcotics such as heroin, narcotic analgesics such as Fentanyl, Norco, Percocet, methadone, Suboxone, Tylenol with Codeine, Kratom, cocaine or other street drugs can be life threatening. I will avoid alcohol. I will also avoid all such medications, prescribed by any other prescribers or off the street and this includes cannabis and all products containing THC.
8. I understand that combining benzodiazepines with alcohol, or narcotic analgesics whether prescribed or from the street may be lethal.
9. I agree to carry my medication in its prescription bottle or carry a copy of the prescription label.

Participant's signature: _____ Date: _____

Prescriber/RN Signature: _____ Date: _____

Participant's Name: _____ Date: _____

10. I agree to take my medication as instructed and not alter the way I take my medication without first consulting my prescriber.
11. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in a treatment program as discussed and agreed upon with my prescriber and case holder.
12. I agree to provide random urine samples when requested by any CMH clinical staff to check for prescribed medication and any substances of abuse or alcohol in my system.
13. CMH prescribers and I have discussed the agreement and I agree that violation of any part of this agreement may be grounds for discontinuation of all controlled substances prescriptions.
14. I agree to sign Release of Information for my prescriber to communicate with any professional prescribing medications for me and exchange my protected health information regarding my mental health and substance abuse history.
15. I have received a copy of this agreement

Participant's signature: _____ Date: _____

Prescriber/RN Signature: _____ Date: _____