TRI-HEALTH
Family wellness center
📍 2253 Green Hedges Way Suite 101 Wesley Chapel, FL 33544
📞 813-771-6851   📠 813-771-6875
✉ info@trihealthfamily.com

Controlled substances policy:

The Florida Legislature has laws governing the prescription of controlled drugs. A drug is classified as a controlled substance based on the relative abuse potential of the drug and the likelihood of its causing dependence. Controlled substance medications (ie, narcotics, benzodiazepines, sleep aids, stimulants and barbiturates) are very useful but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, psychoactive disorders, and other medical conditions, thus improving functions and/or ability to work.

I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances. I understand that the long-term advantages and disadvantages of chronic use have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long-term use of controlled substances and that my Provider will advise me of any advances in this field and will make treatment changes as needed.

I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Drug Monitoring Program website periodically throughout my treatment period.

I must be seen by my provider every month to continue to get refills. Routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the day my provider requests it.

Prescriptions can only be refilled during scheduled appointments. They will NOT be refilled in between appointments, at night or on weekends

Please confirm with your pharmacy if your medication is stock. We are unable to send the same prescription to multiple pharmacies.

Pharmacy: _____Location/ Number _____

Signature _____Date _____
Print Name: _____
Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative