

CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT ENROLLMENT FORM

Date: _____

Patient name: _____

Patient DOB: _____

Patient ID number: _____

Primary care provider: _____

Start date: _____

Stop date: _____

Medication name/strength (1) _____ Sig _____

Number dispensed each month _____ Refills _____

Medication name/strength (2) _____ Sig _____

Number dispensed each month _____ Refills _____

Medication name/strength (3) _____ Sig _____

Number dispensed each month _____ Refills _____

By checking "accept," I the provider am indicating my approval of a standing order for random urine drug-screen testing on this patient. ACCEPT _____ DECLINE _____

Provider's signature: _____ Date: _____