CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT ENROLLMENT FORM

Patient name: _____ Date: _____

Patient DOB: _____ Patient ID number: _____

Primary care provider: _____

Start date: _____ Stop date: _____

Medication name/strength (1) _____ Number dispensed/month _____ Refills _____

Signature _____

Medication name/strength (2) _____ Number dispensed/month _____ Refills _____

Signature _____

Medication name/strength (3) _____ Number dispensed/month _____ Refills _____

Signature _____

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: _____