

# 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: \_\_\_\_\_



**FPM Toolbox** To find more practice resources, visit <https://www.aafp.org/fpm/toolbox>.

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