

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>.

Developed by Deanna R. Willis, MD, MBA. Copyright © 2010 American Academy of Family Physicians. Physicians may duplicate or adapt for use in their own practices; all other rights reserved. Related article: <https://www.aafp.org/fpm/2010/1100/p22.html>.