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: ______________________

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