SEASIDE BEHAVIORAL HEALTH

Benzodiazepine Agreement

Patient Name: _____ DOB:_____

My provider has agreed to prescribe a benzodiazepine circle: [alprazolam (Xanax®), chlordiazepoxide (Librium®), clonazepam (Klonopin®), diazepam (Valium®), lorazepam (Ativan®), oxazepam (Serax®] to manage the symptoms of my psychiatric illness (or manage a side effect from a primary medication) and to help me function better in my life.

I understand the following about benzodiazepine medications:

- If I use a Benzodiazepine daily, it will become less effective over time (tolerance)
- I could suffer withdrawal symptoms if I stop a benzodiazepine abruptly (dependence)
- Benzodiazepine withdrawal can be deadly in some cases
- There is a risk of addiction with benzodiazepine use
- Benzodiazepines have multiple long term side effects, including memory disturbance and increased risk for Alzheimer's Disease

Benzodiazepines are often abused and are very dangerous when used improperly. For this reason, and others, I agree to the following rules regarding my use of this medication:

- I will take medications at the dose prescribed by my provider
- I will take medications at the frequency prescribed by my provider
- I will not change how I take these medications without the prior approval of my provider
- I will not request early refills
- Lost or stolen medications will not be replaced; I am responsible for my medications
- I will arrange for refills at the prescribed interval only during clinical hours
- All prescriptions will be written, at maximum, on a 30 day schedule unless otherwise noted
- I will not request these types of medications from providers outside of Seaside Behavioral Health
- I will keep my complete medication list updated and current with Seaside Behavioral Health
- I will keep appointments with my psychiatric provider at Seaside Behavioral Health
- I will actively participate in the treatment plan as recommended by my provider.
- I agree that I will not use marijuana, alcohol or illicit substances while taking this medication
- I agree that I may be subject to random drug testing and pill counts
- I understand that if my drug screen indicates that I am not taking these medications correctly- my provider can discontinue these medications
- I understand that if my pill count suggests that I am taking the medication differently than prescribed -my provider will discontinue these medications
- I will not sell, trade or give my prescription medication to anyone. I will keep these medications away from children
- I understand that failure to comply with the above may cause my provider to discontinue prescribing these medications
- I understand that if I do not show improvement in symptoms that my provider may stop prescribing these medications
- I understand that my provider may stop these medications if I show significant side effects or intolerance
- If my provider stops prescribing a benzodiazepine to me, s/he will stop it in the safest manner possible

My provider has reviewed the above with me. I have read this agreement and agree to all terms as outlined above.

Patient Name: _____ Patient Signature _____ Date _____

Provider Name: _____ Provider Signature _____ Date _____