WELLSTAR Medical Group
Oncology
In Affiliation with Northwest Georgia Oncology Centers

Prescription Drug Monitoring Program

Beginning July 1, 2018, the state of Georgia has mandated that all providers utilize the Prescription Drug Monitoring Program that tracks prescription drugs to identify and address inappropriate or unsafe patterns of controlled drug use. For your safety, WHS NGOC will access the Georgia Prescription Drug Monitoring Program (PDMP) as required by law to monitor when you fill controlled substance prescriptions.

The providers and staff at WHS NGOC are committed to make prescriptions safer and to provide you with the treatment you need to reduce side effects. In an effort to safeguard your controlled substance prescriptions, please provide the name and contact information of any caregiver who can request controlled substance prescriptions on your behalf:

Name	Relationship	Phone Number
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I agree to the following:

- I will communicate with my provider about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve the pain.
- I am responsible for my medicines. I will not share, sell, or trade my medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- I will safeguard my medications from loss, theft, or unintentional use by others.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor.
- Refills of my controlled substance medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

Please initial by each statement:

____ I understand that my provider will be monitoring my receipt of controlled substance prescriptions through the Georgia Prescription Drug Monitoring Program throughout my treatment period.

____ I authorize my provider and my pharmacy to cooperate fully with any city, state or federal enforcement agency in the investigation of any possible misuse, sale, or other diversion of my controlled substance prescription. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

Patient Name (printed) _____

Patient Date of Birth: _____

Patient Signature: _____ Date:_____