**Patient contract/agreement for reducing benzodiazepine/Z-drug treatment**

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| --- | --- |
| Patient name |  |

I have discussed the gradual reduction of [insert drug] and have agreed that the reduction will be carried out in the following way:

Benzodiazepines/Z-drugs (tablets used for sleeping) are no longer recommended as long-term therapy. The risks of long-term use have been explained to me.

The reduction has been agreed with my doctor/pharmacist and is as follows:

[Delete these instructions before issuing to patient. Insert reduction schedule below-discuss and agree with patient the most appropriate schedule. You may wish to do one step at a time or agree several steps to document on the table below. Delete any rows that are not needed]

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| --- | --- | --- |
| **Date** | **Medicine** | **Dose** |
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I agree that:

* I will not be able to get my prescription earlier than planned without seeing my doctor to discuss why.
* If I feel that I am having problems and explain this to the receptionist, my doctor will try to see me as soon as is reasonable.
* If I am unable to resolve these problems with my doctor I understand that I will be referred to either a voluntary agency or to a hospital specialist team for support and that my medication will not be reduced again until they have seen me.
* Any benzodiazepine/Z-drug tablets in my possession are my responsibility and if I lose/misplace them they will not be replaced.
* I will not get benzodiazepines/Z-drugs from any other source (e.g. other doctors, buying them). I will not exchange them for other drugs or give/sell/lend them to other people.

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| --- | --- |
| Patient name |  |
| Patient signature |  |
| Date |  |

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| --- | --- |
| Doctor’s name |  |
| Doctor’s signature |  |
| Date |  |