***Name***

**INFORMED CONSENT FOR**

**CONTROLLED SUBSTANCE TREATMENT FOR PAIN**

*Nevada law requires a patient’s informed consent before a controlled substance can be initially prescribed to treat the patient’s pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.*

***(Please initial each numbered paragraph and sign below to indicate your understanding of all parts of this document.)***

**POTENTIAL RISKS AND BENEFITS OF USING A CONTROLLED SUBSTANCE FOR THE TREATMENT OF PAIN INCLUDING RISKS OF DEPENDENCY, ADDICTION AND OVERDOSE**

­­­­­\_\_\_\_\_\_\_ I understand there are potential risks and benefits associated with the use of controlled substances for the treatment of pain, and I understand these risks and benefits regarding the medication that I am being prescribed. I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing. When taking these medications, I understand it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel at all sedated, confused or otherwise impaired by the medication, I will not do anything that might put other people at risk of being injured.

\_\_\_\_\_\_ Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises. I understand that I may become physically dependent these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

\_\_\_\_\_\_ I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication, I may need addiction treatment.

\_\_\_\_\_\_ I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana), this risk is increased.

\_\_\_\_\_\_ My practitioner has discussed with me a form of the controlled substance, if available, that is designed to deter abuse, along with the risks and benefits of using that form of the controlled substance.

\_\_\_\_\_\_ My practitioner has discussed possible alternative treatments for my pain that do not include a controlled substance, along with the risks and benefits of the alternate medications or treatments.

\_\_\_\_\_\_ It is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.

**PROPER USE OF THE CONTROLLED SUBSTANCE**

\_\_\_\_\_\_ My practitioner has discussed how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

**TREATMENT PLAN AND REFILLS**

**\_\_\_\_\_\_** I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. A main goal of treatment is to use the minimum amount of controlled substance to increase function rather than to remove all pain.

**\_\_\_\_\_\_** I understand my practitioner’s protocol for addressing any requests for refills.

**\_\_\_\_\_\_** If my treatment for pain with the controlled substance goes beyond thirty (30) days, I understand I will be required to sign and comply with a prescription medication agreement. If treatment exceeds ninety (90) days, I realize that I will be required by Nevada law to complete further assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

**SAFE STORAGE AND DISPOSAL OF A CONTROLLED SUBSTANCE**

\_\_\_\_\_\_It is my responsibility to store and dispose of controlled substances in the appropriate manner. I will store controlled substances in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a “drug take-back day” station, or I may safely dispose of them by dissolving them in a “Dettera” bag, which may be available for purchase at a pharmacy.

**FOR WOMEN IN THE AGES BETWEEN 15 AND 45**

\_\_\_\_\_\_ It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).

**IF THE CONTROLLED SUBSTANCE IS AN OPIOID**

**\_\_\_\_\_\_** Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone is available without a prescription at a Nevada pharmacy. I understand I can obtain this medication from a pharmacist at any time.

\_\_\_\_\_In addition to all of the above, there are increased risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed about ways to detect such abuse, misuse or diversion.

***I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment of pain.***

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Patient Signature Patient name printed Date

For a minor, or for a legal guardian:

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Parent/Guardian Parent/Guardian name printed Date