INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request the physician undersigned as **my physician**, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic pain and other chronic medical conditions.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful. I further understand that these medication(s) are addictive and may produce adverse effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment. Those tests include initial and subsequent random unannounced urine and/or blood test for drugs, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from the treatment program.

For Female patients only: To the best of my knowledge, please check one:
□ I am pregnant.
□ I am not pregnant.
I understand that I must tell my physician immediately if I am pregnant, as the medications prescribed could have an adverse affect upon me and/or my unborn child.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) and other high risk medications for the treatment of my chronic, intractable pain, and other medical conditions.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time.

I understand that no warranty or guarantee has been made to me as to result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines may reverse the action of the medicine I am using for pain control.

CONTROLLED SUBSTANCES AGREEMENT: This informed consent also contains the following important requirements that I must fulfill in order to participate in the treatment Program.

This agreement relates to my use of any controlled substance(s) (i.e., Narcotics, CNS stimulants, benzodiazepines, prescription medications) for my conditions prescribed by my physician and/or any appropriately authorized assistant(s) at its office(s). I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s) for the treatment of chronic pain.

Therefore, controlled substance(s) will only be provided so long as I am actively participating in treatment Program and adhere to the rules specified in this Agreement.

My physician and/or any appropriately authorized assistants(s) may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not improving my quality of life, the narcotics will be discontinued. I will disclose to my physician drugs I take at any time, prescribed by any physician.

I will use the medication(s) exactly as directed by my doctor and/or his appropriately authorized assistant(s).

I will secure my medications prescribed by my physician against accidental ingestion by others.

I further warrant that I will lock my medications in a child-proof container to prevent exposure to children.

All controlled substances must be obtained at the same pharmacy, where possible. I understand that my medication(s) will be refilled on a regular basis.

Refill(s) will not be ordered before the scheduled refill date.

Information that I have been receiving medication(s) prescribed by other doctors, that has not been approved previously by my physician may lead to a discontinuation of medication(s) and treatment.

My physician and/or his appropriately authorized assistant(s) may try alternative medication(s) and/or his appropriately authorized assistant(s), may taper me off of all narcotic(s). I will not hold my physician or any appropriately authorized assistant(s), and/or any other member of

Addiction Care of Excellence staff liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens initially as my physician may, in his or her discretion, order. If I test positive for illegal substance(s), at any time, the treatment program may be terminated and I may be discharged from the care of my physician.

I hereby give my physician and any appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any pharmacist(s) regarding my use of controlled substance(s).

I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

_____	_____	_____
Patient Signature	Patient Full Name	Date
_____	_____	_____
Physician or Appropriately Authorized Assistant Signature	Full Name	Date