

Place institution logo and name here.

NOTICE OF THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF INTRACTABLE PAIN AND PATIENT'S INFORMED CONSENT

Please print clearly.

This will confirm that you have been diagnosed with _____, a condition causing you intractable pain. I have recommended treating your condition with the following controlled substance(s): _____. There may be alternative methods of treatment available to you.

The material risks associated with _____ include, but are not limited to:

- sedation that may interfere with your ability to drive and operate machinery safely;
- interference with breathing, urinary and bowel function (constipation) serious enough to warrant urgent medical treatment;
- physical dependence;
- addiction;
- nausea, vomiting, itching, mood changes, muscle twitching, and allergic reactions; and
- injury to the fetus or unborn child in a pregnant woman.

Physical dependence is an inevitable consequence of chronic opioid use. This involves the body's becoming used to having the medication present. If someone who is physically dependent on a medication discontinues the use of that medication suddenly, he or she may experience an uncomfortable withdrawal syndrome.

Addiction is not the same as physical dependence, although the two may overlap. Addiction involves the compulsive use of a substance, against a provider's instructions, for unintended purposes. It may also involve unauthorized increases in medication or diversions of medication.

This will also confirm that I asked if you wanted a more detailed explanation of the proposed treatment, alternatives, and material risks and that you (check one):

- were satisfied with the above description and did not want any more information.
- requested and received, in substantial detail, further explanation of the treatment, alternative methods of treatment, and information about the material risks.

If this accurately represents our discussion and if you are satisfied with the explanation given, you must sign this document indicating your informed consent to use this controlled substance before commencement of treatment.

Signature of Patient: _____ Date: _____

Print Name of Patient: _____

Provider

Explained by me and signed in my presence:

Signature of Provider: _____ Date: _____

Print Name of Provider: _____