INFORMED CONSENT FOR USE OF CONTROLLED SUBSTANCES FOR PAIN MANAGEMENT

Your healthcare provider has determined that your pain may be managed through the use of controlled narcotics for pain control. The purpose of this agreement is to comply with applicable laws and regulations and to prevent any misunderstandings regarding use of the prescribed controlled medications.

Risks & Benefits:
Opioid analgesics are effective when used for pain control. These medications act on the central nervous system to decrease the perception of pain. The use of these medications can lead to tolerance, addiction, and dependence. Some additional side effects associated with the use of opiate narcotics for pain management are listed below:

1. Sedation
2. Constipation
3. Nausea and vomiting
4. Confusion or change in thinking abilities
5. Difficulty with balance.
6. Sleepiness and drowsiness
7. Decreased respiration or breathing
8. Physical dependence, which means if you abruptly stop taking this medication, you may begin withdrawal. Signs of withdrawal include diarrhea, abdominal cramping, "goose flesh", and anxiety
9. Risk regarding pregnancy: children born to mothers on opioids will likely be physically dependent to the drug at birth

Many of these side effects may make heights unsafe and contribute to making it unsafe to operate motor vehicles or heavy equipment.

PATIENT agrees that he/she has been informed of the risks and benefits of his/her treatment plan for pain, which includes the use of opioid analgesics. All of his/her questions and concerns have been adequately addressed. Patient's signature indicates that they understand the risks and benefits associated with controlled substances for pain management and have agreed with their use. Patient also acknowledges that they are aware that their prescription history of controlled substances will be obtained as required by KY state law (using the KASPER reporting system) by their provider or his/her designee prior to prescribing controlled substances.

_____   _____
Patient signature   Date   Physician signature   Date

_____
Witness signature   Date