Oklahoma State board of Medical Licensure and Supervision

INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Patient: _____ Provider: _____

Medication list: Please list your medications here or provide a list to attach to this agreement

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

In accordance with Oklahoma Law SB1446, prior to giving me a controlled substance prescription, my provider is required to discuss with me the risks of taking controlled dangerous substances specifically any form of Opiates and the potentially dangerous interaction with some other prescription drugs. Due to the seriousness of the Oklahoma Opioid Abuse Crisis, the physician is asking me to sign this form to acknowledge our conversation.

My provider has explained to me that these medications may include opioids and/or other drugs that can be used to treat pain, anxiety, insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision.

I further understand that taking these medications can lead to tolerance, physical dependence, and/or developing in addictive disorder. Stopping the medication abruptly may lead to withdrawal symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

- □ Constipation
- □ Nausea/vomiting
- □ Excessive drowsiness or sleepiness
- □ Itching
- □ Urinary retention (inability to urinate)
- □ Low blood pressure
- □ Irregular heart rate
- □ Inability to sleep
- □ Depression
- □ Impaired judgment and/or reasoning
- □ Respiratory depression (slow or no breathing), which could be fatal
- □ Impotence
- □ Tolerance to medications
- □ Physical or psychological dependence
- □ Addiction
- □ Death

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications. The risks, benefits and alternative treatments, including the risks and benefits have been explained to me.

I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

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For female patients in childbearing age:
I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

For minors:
I have been formed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

Additionally, I have been informed of:

- Proper use, storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects - opioid antagonist w/o a prescription

The goal of this treatment is for the management of my current medical condition which is:
_____
_____.

I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance (s). My provider has explained alternative options to the use of opiates and may utilize those options based on my treatment plan prognosis.

I authorize and direct my provider to prescribe controlled substances. I understand in order to initiate or continue treatment with controlled substances I must agree to the conditions set forth above. I also consent to the use of drug testing either in the form of urinalysis or serum drug toxicology screening as deemed fit or appropriate by the prescribing provider.

_____ _____
Signature of Patient/Representative Date Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all questions fully and I believe the patient/legal representative fully understands what I have explained.

_____ _____
Provider signature Date Time