This is a sample for prescribers' use as they deem appropriate, but it is each prescriber's responsibility to ensure proper informed consent in compliance with AB474.

Informed Consent for Controlled Substance Therapy for Pain

In Nevada, per Assembly Bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the medication(s) prescribed. Please review the information listed here and initial each item.

_____ I understand that I am being prescribed medications, including controlled substances for the treatment of pain.

_____ I understand that all pain medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

_____ I understand that prescription controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

_____ I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber).

_____ Before I was prescribed this pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but not limited to anti-inflammatories (i.e., Aleve, Tylenol, Ibuprofen, etc.).

_____ I understand that when I take controlled substance(s), I may experience certain reactions or side effects that could be dangerous, including, but not limited to, sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

____ I understand that when I take controlled substance(s), it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.

_____ I understand that when I take controlled substances, I may become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

SAMPLE

_____ I understand that I may become addicted to controlled substances and require addiction treatment if I cannot control how I am using them, or if I continue to use them for a prolonged period of time. I have discussed with my prescriber the proper use of the controlled substance.

_____ I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

_____ I understand that I must store prescriptions in a secure place and out of the reach of children, other family members and others and/or use a locked medicine cabinet. To safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am not to dispose of unused medications into the toilet or sink.

_____ I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if s/he believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

_____ I understand that due to the risk of possible overdose resulting from of controlled substances, the opioid overdose antidote naloxone (Narcan®) is now available without a prescription. I may obtain naloxone (Narcan®) from a pharmacist.

_____ For **Women:** It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

Informed Consent:
I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions that I may have regarding my treatment of pain with medications, including controlled substances, and am satisfied that my questions have been answered.

___________________________ ________________________________ _____________

Patient Name printed Patient Signature Date

Unemancipated Minor:
As the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

___________________________ ________________________________ _____________

Parent/Guardian Name printed Parent/Guardian Signature Date

Your office name, street, city, state, zip, phone number

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