



Treatment with Controlled Substances

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give permission for my entire prescription history to be obtained from my pharmacy.

\_\_\_\_\_
Witness

\_\_\_\_\_
Patient Signature or Person Authorized
to Consent for Patient

\_\_\_\_\_
Date

\_\_\_\_\_
Time

\_\_\_\_\_
Relationship to Patient