Lisa Haworth, MD
2482 W Horizon Ridge Parkway, Ste 110
Henderson, NV 89052

INFORMED CONSENT FOR CONTROLLED SUBSTANCE TREATMENT FOR PAIN

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please initial each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

POTENTIAL RISKS AND BENEFITS OF USING A CONTROLLED SUBSTANCE FOR THE TREATMENT OF PAIN INCLUDING RISKS OF DEPENDENCY, ADDICTION AND OVERDOSE

_____ I understand there are potential risks and benefits associated with the use of controlled substances for the treatment of pain, and I understand these risks and benefits regarding the medication that I am being prescribed. I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing. When taking these medications, I understand it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel at all sedated, confused or otherwise impaired by the medication, I will not do anything that might put other people at risk of being injured.

_____ Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises. I understand that I may become physically dependent these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

_____ I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication, I may need addiction treatment.

_____ I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana), this risk is increased.

_____ My practitioner has discussed with me a form of the controlled substance, if available, that is designed to deter abuse, along with the risks and benefits of using that form of the controlled substance.

_____ My practitioner has discussed possible alternative treatments for my pain that do not include a controlled substance, along with the risks and benefits of the alternate medications or treatments.

_____ It is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.

PROPER USE OF THE CONTROLLED SUBSTANCE

_____ My practitioner has discussed how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

TREATMENT PLAN AND REFILLS

_____ I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. A main goal of treatment is to use the minimum amount of controlled substance to increase function rather than to remove all pain.

_____ I understand my practitioner's protocol for addressing any requests for refills.

_____ If my treatment for pain with the controlled substance goes beyond thirty (30) days, I understand I will be required to sign and comply with a prescription medication agreement. If treatment exceeds ninety (90) days, I realize that I will be required by Nevada law to complete further assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

SAFE STORAGE AND DISPOSAL OF A CONTROLLED SUBSTANCE

_____It is my responsibility to store and dispose of controlled substances in the appropriate manner. I will store controlled substances in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a "drug take-back day" station, or I may safely dispose of them by dissolving them in a "Dettera" bag, which may be available for purchase at a pharmacy.

FOR WOMEN IN THE AGES BETWEEN 15 AND 45

_____ It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).

IF THE CONTROLLED SUBSTANCE IS AN OPIOID

_____ Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone is available without a prescription at a Nevada pharmacy. I understand I can obtain this medication from a pharmacist at any time.

_____In addition to all of the above, there are increased risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment of pain.

_____	_____	_____
Patient Signature	Patient name printed	Date

For a minor, or for a legal guardian:

_____	_____	_____
Parent/Guardian	Parent/Guardian name printed	Date

Lisa Haworth, MD
2482 W Horizon Ridge Parkway, Ste 110
Henderson, NV 89052

PRESCRIPTION MEDICATION AGREEMENT
FOR
CONTROLLED SUBSTANCE TREATMENT OF PAIN

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities of which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please initial within each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

Regarding my treatment plan and he goals of the treatment of my pain, including the appropriate use of a controlled substance.

_____I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain.

_____ I understand that part of the goals of my pain management therapy may be to minimize or even to discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means; the presence or development of side effects; any signs of misuse, abuse, diversion, or addiction; refusal to comply with diagnostic studies or other aspects of the treatment plan; attempts to obtain medication from other providers; use of illicit drugs or other medications that may interact with the controlled substance; or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.

_____ I hereby reaffirm my consent to monitor my drug use when my practitioner deems it appropriate or necessary, including, without limitations, urine, hair, and blood testing as well as bringing my medications to the prescriber's office where the number of pills may be counted.

_____ I reaffirm that I will take the prescribed controlled substance only as prescribed.

_____ I will not share my medication with any other person.

_____ I agree to inform my practitioner of any other controlled substance prescribed to me or taken by me.

_____ I will immediately disclose to my practitioner of any alcohol consumed by me and of any marijuana products, including cannabinoids, I may use or consume while taking the controlled substance for the treatment of my pain.

_____ I will disclose to my practitioner whether I have been treated for side effects or complication relating to the use of the controlled substance, including whether I have experienced an overdose.

_____ I understand that Nevada state law requires me to provide a listing of every State in which I have previously resided or had a prescription for a controlled substance filled. Below is a listing of such states:

---------- ----------

---------- ----------

---------- ----------

---------- ----------

_____ I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children, and I will dispose of unused medication appropriately.

_____ I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.

_____ I understand that prescriptions will only be provided during scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance).

_____ I understand that my medication is my responsibility and if it is lost or stolen, the medication may not be replaced until my next appointment, at the judgment of my prescriber.

_____ If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk for abuse, dependency and addiction using validated tests. I agree to cooperate for those tests. I understand I will also be required to undergo appropriate testing to determine an evidence-based diagnosis for the cause of my pain. My practitioner may also refer me to a specialist for consultation or for further treatment.

_____ **I hereby authorize my practitioner to obtain records from other practitioners or clinics, and speak to other practitioners about my current or prior medical care.**

_____ It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

_____ I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies investigation, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Occupational Licensing Boards.

I understand that if I violate any part of this agreement, I may be denied prescriptions for controlled substances and I may be discharged from the clinic.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain.

_____	_____	_____
Patient Signature	Patient name printed	Date
_____	_____	_____
Parent/Guardian	Parent/Guardian name printed	Date

_____ _____

Patient's Name **Date**

Controlled Substance Questionnaire

N/A means not applicable.

	YES	NO	N/A
Have you ever used a controlled substance in a way other than prescribed?	_____	_____	_____
Have you ever diverted a controlled substance to another person?	_____	_____	_____
Have you ever taken a controlled substance that did not have the desired effect?	_____	_____	_____
Are you currently using any drugs, including alcohol or marijuana?	_____	_____	_____
Are you using any drugs that may negatively interact with a controlled substance?	_____	_____	_____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	_____	_____	_____
Have you ever attempted to obtain an early refill of a controlled substance?	_____	_____	_____
Have you ever made a claim that a controlled substance was lost or stolen?	_____	_____	_____
Have you ever been questioned about your pharmacy report or PMP report?	_____	_____	_____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	_____	_____	_____
Have you ever been accused of inappropriate behavior or intoxication?	_____	_____	_____
Have you ever increased the dose or frequency of meds without telling your provider?	_____	_____	_____
Have you ever had difficulty with stopping the use of a controlled substance?	_____	_____	_____
Have you ever demanded to be prescribed a controlled substance?	_____	_____	_____
Have you ever refused to cooperate with any medical testing or examinations?	_____	_____	_____
Have you ever had a history of substance abuse of any kind?	_____	_____	_____
Has there been any change in your health that might affect your medications?	_____	_____	_____
Have you misused or become addicted to a drug, or failed to comply with instructions?	_____	_____	_____
Are there any other factors that your practitioner should consider before prescribing?	_____	_____	_____

_____ _____ _____

Patient's Signature Patient's Printed Name Date

_____ _____ _____

Parent/Legal Guardian Parent/Legal Guardian Date

_____ _____

Patient's Name **Date**

PRESCRIPTION OPIOD MISUSE INDEX

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you?

Yes No

2. Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages?

Yes No

3. Do you ever feel high or get a buzz after using your pain medication?

Yes No

4. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?

Yes No

5. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication?

Yes No

6. Do you ever need early refills for your pain medication?

Yes No

_____ _____ _____

Patient's Signature Patient's Printed Name Date