Narcotic/ Scheduled Medication Consent Form

I hereby consent to the use of Narcotic/ scheduled medications prescribed to me for the means of achieving a higher level of daily functioning. I agree to be open, honest and have regular communication with my provider to monitor my use of scheduled/ controlled medication.

The potential risks of narcotic/ scheduled medication include, but are not limited to:

- **Addiction**
- **Interference with Physical and/or Mental Functioning**

Narcotics/ scheduled medications may interfere with driving, operating machinery or other requirements of my job. I understand it is my responsibility to avoid these risks.

- **Physical Dependence**

I understand that abrupt discontinuation of a narcotic/ scheduled medication drug may cause nausea, vomiting, suicidal thoughts and sweating.

- **Tolerance**

I understand that in the future, narcotics/ scheduled medications may no longer work to manage my symptoms. It will be necessary to slowly taper from the medication and to develop other behaviors for management (e.g., exercise, healthy diet, stress management, etc.).

- **Pregnancy Risk**

I understand that narcotic/ scheduled drugs affect a developing fetus and may result in birth defects. I agree to inform my provider if I am currently pregnant or should become pregnant during the course of my treatment.

Patient Agreement

1. I agree not to take scheduled medications from ***any*** other source, unless approved.
2. I agree to inform my provider of any other medications I take during this time.
3. I agree to allow my provider to set the interval at which I may request narcotic/ scheduled prescriptions.
4. I agree to practice pain management behaviors regularly.

5. I agree to provide a urine sample for drug screening, upon request.
6. I will not alter my prescription in any way.
7. I agree to fill my prescription through one pharmacy, and will notify my doctor and both pharmacies of any change.
8. I understand that prescriptions will be processed within 24-48 hours.
9. I agree that I have been instructed to go to pain management but have states I am home bound and unable to get to pain management for treatment.
10. I understand that I am being treated with pain medication because I am home bound and that if I become able to leave my home (FOR ANY REASON), I will start a pain management program
11. I understand that I can be refused scheduled medications at any time.
12. I understand that violation of any of the above may result in the termination of my doctor/ patient relationship.
13. I understand that stolen pills will require a police report, should any future refills be given. I understand there is no guarantee they will be refiled and that lost pills will not be refilled.

There may be specific risks that pertain to my illness. There is a small chance these risks have gone undiagnosed. I have been given the opportunity to explore alternative methods for evaluation and pain management. I have been allowed to ask any questions regarding my pain control.

I hereby give my consent freely, voluntarily and without reservation.

Patients Name:_____ **HCP (If Applicable)**_____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Pharmacy Name and Address:_____