

Consent for a Controlled Substance

between Primary Physician and their Patient

Purpose: The purpose of this consent is to inform you that these drugs have the potential for abuse or diversion in our community and therefore strict accountability is necessary.

Because my physician/health care provider is prescribing such medication to assist in the management of my pain, I agree to the following conditions:

1. I am responsible for my pain medications, and I agree to take the medications only as prescribed.
2. I agree to safeguarding my community by understanding that my medications may be sought by individuals with a substance dependence or for the purpose of selling, therefore it is my responsibility to ensure that others do not have access to them. I agree to have the medications in a secure area that only I have access to (locked box – locked cabinet, for example)
3. I agree that my controlled substance will be obtained at the same pharmacy and should the need arise to change pharmacies I will advise my physician.

Pharmacy: _____

Location: _____

4. I understand that the opioid medication is strictly for my own use. I may not share, sell, trade, exchange my medications for money, goods or services, or otherwise permit others to have access to my medications. If I alter or counterfeit my fentanyl patches in any way I shall be charged with a criminal offense.
5. I understand by signing this consent if I return a counterfeit patch into the pharmacy it will be immediately reported to the police that the patch is suspicious. The police will send the patch away to be confirmed. My physician then has the right to discontinue the medication or promptly terminate care.
6. I understand that if I alter or submit a counterfeit Fentanyl patch I am waiving my rights to confidentiality as the pharmacy and physician have the right to contact the legal authorities or regulatory agencies to provide information regarding my actions. For example, the pharmacist shall notify the physician as well as the appropriate police service immediately that they suspect the patch to be counterfeit.

I, _____, have read the above information or it
(Print name)

has been read to me and all questions have been answered to my satisfaction. I hereby give my consent to participate in the opioid treatment and understand the consequences if I do not follow the guidelines. I acknowledge receipt of this document.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____