Informed Consent – Example

___ **Diagnosis**

I understand that I have been diagnosed as having:_____

_____

___ **Use of opioids**

I understand that I will be prescribed opioid analgesics, otherwise known as narcotic pain medication, because my chronic pain is caused by a serious condition that has not been successfully treated by other medication.

___ **Side Effects of the Medication**

I understand that the medication I will be taking may cause side effects to include, but not limited to: sleepiness or drowsiness, constipation, nausea, vomiting, dizziness, an allergic reaction, the medication may cause my breathing to become slower, my reflexes and reaction time may slow down.

___ **Operating a Motor Vehicle**

I understand that because of these side effects it may be unsafe or even dangerous for me to operate a motor vehicle or machinery of any type. I also understand that these side effects may impair me from doing all activities including work.

___ **Physical Dependency**

I understand that I may become physically dependent on the medication that I may be prescribed. I understand that being physically dependent on medication means that my body becomes used to the medication and if I immediately stop taking the medication I may experience withdrawal. I understand that withdrawal may cause me to experience anxiety, become agitated, experience muscle aches, tearing, problems sleeping, runny nose, sweating, yawning, abdominal cramping, diarrhea, dilated pupils, nausea or vomiting.

___ **Tolerance to Medication**

I understand that I may experience tolerance to the medication that I may be prescribed. I understand that tolerance means that after taking the medication for a period of time, the medication may no longer be effective in managing my pain.

My signature indicates that I understand each of the issues explained to me. I also agree to my responsibilities contained in this document.

_____

Patient's Signature Date

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page:

_____

Staff's Signature Date

___ **Addiction**
I understand that taking prescription narcotic pain medication could result in addiction or death. I understand that addiction is a disease that may cause me to continuously crave the medication. I also understand that addiction is a lifelong condition that requires lifelong treatment and counseling.

___ **Amount of Pain Relief**
I understand that the medication that I will be prescribed for my pain will not provide me total pain relief.

___ **Result of Aberrant Behavior**
I understand that I shall take the prescribed medication only as directed by Dr._____ or his/her staff. I further understand that if I take more medication than directed, I will be placing myself at risk of severe harm, addiction or death.

___ **Therapeutic Effect**
I understand that prescription pain medication will only be prescribed if the medication is providing me a more productive lifestyle and managing my pain. I understand that if the medication no longer manages my pain, I will either be taken off the medication or my medication will be changed.

___ **Identification of Alternative Treatment Options**
I am aware that Dr. _____ or his/her staff has discussed the possible benefits and risks of other treatments that do not include opioid therapy, otherwise known as narcotic pain medication. These treatments include:_____

_____

___ **Consent for Treatment**
I understand my condition and I voluntarily request that Dr. _____ and/or his/her staff treat my condition. I further authorize Dr. _____ and/or his/her staff to administer or write prescriptions to me for the purpose of treating my chronic pain.

My signature indicates that I understand each of the issues explained to me. I also agree to my responsibilities contained in this document.

_____
Patient's Signature Date

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page:

_____
Staff's Signature Date

____ **Right to Discontinue Treatment or Medication**
I understand that I may discontinue using my medication at any time and I agree to notify Dr._____ immediately upon discontinuing the use of my medication. I understand that I may be provided supervision if needed by Dr. _____ if I choose to discontinue my medication.

____ **Face-to-Face Consultation for Refills**
I understand that my medication cannot be refilled without a face-to-face appointment with Dr._____ or his/her staff. Understanding this, I realize that I will have to make an appointment to come to the clinic to be examined by Dr. _____ or his/her staff in order to obtain a refill.

____ **Importance of Attending Scheduled Appointments**
I also understand that Dr. _____and his/her staff has many patients and if I fail to show up for my appointment, I may not be able to be seen by Dr. _____or his/her staff until an opening is available. I understand that an opening may not be available for up to two weeks.

____ **Need to Assess Progress**
I understand that I will meet regularly with Dr. _____ or his/her staff to assess my progress, side effects and benefits of taking the medication prescribed to me or to discuss proper medication or treatment plan adjustments.

____ **Disclosure of New Medical Condition**
I agree to disclose any new medical condition that I have experienced during my scheduled appointments.

My signature indicates that I understand each of the issues explained to me. I also agree to my responsibilities contained in this document.

_____
Patient's Signature Date

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page:

_____
Staff's Signature Date

Note: Scott Huckabee is not a lawyer and he is not attempting to provide you legal advice. Feel free to use this material in your practices. Any other use of this material is prohibited. Be sure to gain advice from your attorney prior to establishing any of this information as your policy or practice.