MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)* *LONG TERM CONTROLLED SUBSTANCE THERAPY INFORMED CONSENT/AGREEMENT*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)* ***SPECIAL REQUEST AND AUTHORIZATION***	

Side Effects

Possible side effects include mood changes, drowsiness, dizziness, constipation, nausea, itching, and/or confusion. Many of theses side effects, if they occur, gradually resolve over days to weeks. Constipation often persists and may require management with medication. If other side effects persist, trials of alternative medications may be necessary or medications may need t**o** be discontinued. You should not drive a car or other vehicle or operate machine if the medications make you drowsy. The sedating effects of alcohol and other sedatives are additive with the side effects of most controlled substances. It is strongly advised that you avoid alcohol while receiving controlled substance therapy.

Physical Dependence

Physical dependence is an expected side affect of long-term controlled substances if they are prescribed on a daily basis. This means that you take controlled substances continuously and stop them abruptly for any reason, you will experience a withdrawal syndrome. This syndrome often includes swearing, diarrhea, irritability, sleeplessness, running nose, tearing, muscle and bone aching, stomach cramps and dilated pupils. To prevent these symptoms, medications must be taken regularly if physical dependence is present. When cont4rolled substance medications are discontinued, they should be tapered under the supervision of your physician. Do not abruptly stop taking your prescription without consulting your physician.

Addiction

Addiction is present when an individual experiences loss of control over the use of medications, is constantly seeking medications, and or/ experiences adverse consequences as a result of medication use, yet continues to take the medication . Most patients who use controlled substances for the treatment of discomfort caused by their condition are able to take medications as prescribed on a scheduled basis, do not seek other medications when their condition is controlled, and experience improvement in the quality of life as a result of the controlled medications; thus they are NOT addicted. Physical dependence does NOT indicate addition. Individuals with a history of alcoholism or other drug addictions are at an increased risk for the development of addictions are at an increased risk of the development of addiction while using controlled medications.

Tolerance to Medication

Tolerance to the desired effects of controlled medications is possible with continuous use. This means that although there has been no physical change in the underlying condition, an increased does of medication is required to achieve the same level of discomfort control experienced when the medications were initiated. We do not fully understand why, or understand under what conditions tolerance to the relieving effects of controlled medication. When it does occur, it sometimes requires tapering and discontinuation of the medication. Sometimes tolerance can be handled by substituting a different medication in the same classification.

Risk to Unborn Children

Children born to women who are regularly taking controlled medications will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on controlled medication therapy. Should you become pregnant, immediately contact your physician. The medication will be tapered and stopped.

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
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Long Term Controlled Substance Therapy Informed Consent/Agreement

Prescription and use of Medications (please initial beside each statement

- ☐ I will not received a new prescription or refill of this type of prescription or other addictive medications such as sleeping pills, tranquilliser, or stimulants from other providers without authorizations from my sole provider.
- ☐ I will inform my sole provider's office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications I take.
- ☐ I will take my medication only as prescribed.
- ☐ I understand that "as needed" does not mean I have to take the maximum dose allowed for the day.
- ☐ I understand that any changes to my prescription must be made by my sole provider and my require a face to face visit.
- ☐ I understand that all of my medications will be picked up at the Naval Hospital Pharmacy unless the Naval Hospital Pharmacy does not carry my prescribed medication.
- ☐ I understand the noncompliance is the #1 reason to lose my prescribing physician's trust, and compromises the future ability of my physician to give me the "benefit of the doubt" in prescribing these medications.
- ☐ ***I understand that a lost or misplaced prescription, or suspecting that someone else may possess my medication will require me make a report with the civilian or military police and provide my sole provider with a copy of their report. A substitute prescription may not be filled until this is done.***
- ☐ I understand that disposing of or destroying my medication either myself and/or by another party without my sole provider's prior knowledge can be terms for discontinuing controlled substance therapy.
- ☐ I understand that prescriptions will only be filled during normal working hours at the clinic and that renewals are contingent on keeping scheduled appointments.
- ☐ I understand that these medications should **never** be shared or sold; this obviously against the law.
- ☐ Il understand that these drugs can be hazardous or lethal to someone not tolerant of them, **especially children, and need to be kept out of their reach. This is an important responsibility for the safety of others and I understand that accepting possession of these medications carries legal responsibilities..**
- ☐ I understand that I may be required to bring my medications in for reconciliation to monitor compliance at any time.
- ☐ I understand that my provider may request that I submit a blood or urine sample to help monitor compliance. It is possible that I may be observed while producing a specimen.
- ☐ Il understand that inconsistent laboratory results may result in discontinuation of medications and /or being discharged from the clinic.
- ☐ I understand that my provider may request to receive other health care information from another provider or pharmacist about my use or possible misuse/ abuse of opioids, alcohol, or other substances.
- ☐ I understand that if responsible legal authorities have questions concerning my treatment, as might occur, if I were obtaining medications from multiple providers and /or multiple pharmacies, all confidentiality is waived and these authorities may be given full access to controlled substance administration records.
- ☐ I understand that these medications have the potential to be addictive, ***especially if used inappropriately***, and that I may be asked to be seen by a specialist, including Psychiatry or an Addiction Specialist, if recommended or if signs of addiction are present.
- ☐ I understand that it is important to inform my sole provider if I do become pregnant or suspect that I may be pregnant.
- ☐ I understand that controlled medication therapy is one part of the treatment for my condition and that I may be required to actively participate in other medical treatments including but not limited to physical therapy, occupational therapy, mental health, etc.
- ☐ I understand that my medications will be continued as long as there is demonstrated improvement in my pain level and/or function, and I remain compliant with my regimen, as determined by my sole provider.
- ☐ ***I understand that my provider will gradually take me off my opioid medications, refer me for detoxification, or immediately discontinue my controlled substance with the use of medications to control withdrawal symptoms if I do not follow the above plan, or if it appears the opioids may be harming me.***

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Strict Compliance

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. Strict compliance with your provider's dosing instructions is essential to give you the best chance of long term benefit. Compliance will also help reduce side effects and tolerance to these medications. You will be given enough medications for what is usually a short trial. If successful, refills may be done with no more than one month's supply at a time, or sooner as determined by your provider. It is important that you receive these medications only through the prescribing provider or alternate on this agreement.

I, _____ (Print Patient Name), _____ (DOB) have agreed to use _____ (Print classification of medication being prescribed) medications as part of my treatment of _____ (Print diagnosis and/or condition being treated). I understand that these medications my not completely eliminate the discomfort caused by my condition but may reduce my symptoms and improve functionality. I agree to have one provider, _____ (Sole Provider's Printed Name) who can be reached at _____ (Phone Number), prescribe all medications. In the event that the above provider is not available, _____ (Sole Provider's Printed Name) will be the alternate prescribing provider/clinic to manage my condition.

Patient Signature _____ Date _____

Provider's Signature _____

Witness Signature/ Printed Name _____

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