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INFORMED CONSENT FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Patient:_____ Provider: David P Biesinger, DPM

Medication list: Please list your medications here or provide a list to attach to this agreement

In accordance with Nevada law AB 474, prior to giving me a controlled substance prescription, my provider is required to obtain my written informed consent.

My provider has explained to me that these medications may include opioids and/or other drugs that can be used to treat pain, anxiety, insomnia, attention deficit disorder, depression and other conditions. I understand that these medications have known risks and side effects, and can be harmful if taken without medical supervision. I further understand that taking these medications can lead to tolerance, physical dependence, and/or developing in addictive disorder. Stopping the medication abruptly may lead to withdrawal symptoms and/or psychological dependence or addiction that is an abnormal psychological craving of the medication to the point of becoming a danger to oneself or others.

I understand that the most common side effects that can occur with the use of these medications include but are not limited to:

- Constipation
- Nausea/vomiting
- Excessive drowsiness or sleepiness
- Itching
- Urinary retention (inability to urinate)
- Low blood pressure
- Irregular heart rate
- Inability to sleep
- Depression
- Impaired judgment and/or reasoning
- Respiratory depression (slow or no breathing), which could be fatal
- Impotence
- Tolerance to medications
- Physical or psychological dependence
- Addiction
- Death

I further understand that it may be dangerous for me to operate a motor vehicle or other machinery while taking these medications.

The risks, benefits and alternative treatments, including the risks and benefits have been explained to me. I understand that not every possible risk and benefit is listed on this form and that this consent includes the most common side effects or reactions. I acknowledge that I have been warned about the dangers of overdose and/or combining the prescribed medications with other drugs or alcohol may cause serious illness or death.

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For female patients in childbearing age:

I understand that there are unknown side effects of the prescribed medications that could harm an unborn child. If I am not pregnant, I will use appropriate contraception (birth control) during the course of my treatment. If I become pregnant or am uncertain, I will notify my provider immediately.

For minors:

I have been formed of the risks that my child may abuse, misuse or divert these controlled substance medications. I have been informed of the ways to detect such misuse.

Additionally, I have been informed of

- Proper use, storage and disposal of these medications
- How refills will be addressed
- If the medication is an opioid, I understand that I can get the medication to counteract its effects (an opioid antagonist) without a prescription

The goal of this treatment is for the management of my current medical condition. I understand that my treatment plan will be tailored for me. I further understand that I may withdraw from this treatment plan and discontinue medication use at any time. I understand that prior to doing so I need to inform my provider since there may be a medical risk associated with abrupt termination of these medications.

I have been given an opportunity to ask questions about my condition and treatment and the risks and benefits of the prescribed controlled substance (s).

I authorize and direct my provider to prescribe controlled substances. I understand in order to initiate or continue treatment with controlled substances I must agree to the conditions set forth above.

I also consent to the use of drug testing either in the form of urinalysis or serum drug toxicology screening as deemed fit or appropriate by the prescribing provider.

_____ _____ _____

Signature of Patient/Representative Date Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the prescribed medications to the patient or patient's legal representative. I have answered all questions fully and I believe the patient/legal representative fully understands what I have explained.

_____ _____ _____

Provider signature Date Time

OPIOD RISK TOOL

Dear Patient, this tool should be administered to patients upon initial visit and/or prior to beginning opioid therapy for pain management.

In the chart below, please circle whether you are male or female. Then under column 1, please circle any of the situations that applies to your particular circumstances. For instance, if you had a mother or father with a history of alcohol abuse, you will circle “Alcohol” under column 1 for family history. If you personally have a history of illicit drug abuse then you will circle “ Illicit drugs” under column 1 for personal history. You may leave column 2 and column 3 empty. Your doctor will total the score for you.

A score of 3 or lower	Indicates low risk for future opioid abuse
A score of 4-7	Indicates moderate risk for opioid abuse
A score of 8 or higher	Indicates a high risk for opioid abuse

Mark Each Box That Applies	Female	Male
Column 1	/Column 2	/Column 3
Your Family History of Substance Abuse		
Alcohol	1	3
Illicit Drugs	2	3
Prescription Drugs	4	4
Your Personal History of Substance Abuse		
Alcohol	3	3
Illicit Drugs	4	4
Prescription Drugs	5	5
Age Between 16-45 Years	1	1
History of Pre-Adolescent Sexual Abuse	3	0
Psychological Disease		
ADD/HD, Schizophrenia, OCD, Bipolar	2	2
Depression	1	1

Scoring Totals

Provider Signature