Consent Form for Opioid Use

Informed Consent for Opioid Use

I have agreed to use opioids as part of my treatment to manage related chronic or post-operative pain. I understand that these drugs are useful in managing my pain, but have a high potential for addiction and/or dependency.

I understand that I can discuss possible alternatives for this opioid prescription with my podiatrist and have furnished a complete and accurate medical history (including pregnancy, if applicable) and list of the medications I currently am taking or have taken in the last 6 months, including information about mental history and drug and/or alcohol use.

Because my podiatrist is prescribing such medication to manage my pain, I acknowledge that I have been made aware of the following information and agree to the following conditions:

1. I am responsible for my pain medications and agree to take the medication not more frequently than prescribed and only if needed to manage pain. I understand that increasing my dose without my podiatrist's knowledge could lead to a drug overdose causing severe sedation and respiratory depression and possibly death.

2. Without prior disclosure to my podiatrist, I will not request or accept controlled substance medication from any other healthcare provider or individual while I am receiving such medication from my podiatrist.

3. There are side effects with opioid medications, which may include, but not be limited to, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, confusion, depression, increased sensitivity to pain or the possibility of impaired motor ability. As a result, when I take these medications, it may not be safe for me to drive a car, operate machinery or take care of other people.

4. I have been made aware that I may become addicted to these medications (opioids) and may require addiction treatment. Overuse of this class of medication can lead to physical dependence and the experience of withdrawal sickness if I stop use or cut back too quickly. Withdrawal symptoms feel like having the flu and may include: abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety and sleep problems.

5. I understand that the opioid prescription I have been given is for my own use and attest that I will not give or sell any portion of the prescription to another individual.

6. I understand I should store my medication in a safe place, where it cannot be reached by children or stolen by family or visitors in my home. To reduce chance of accidental or intentional taking of my medication, I will promptly dispose of any unused medications.

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Patient, Parent or Guardian Signature Date