

MRN \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

## Prescribed Opioid Informed Consent

Your provider has prescribed opioids to treat your pain. It is important for you to understand the risks associated with this medication. While opioids can be effective at treating acute (sudden or short-term) pain, using them even for a short time can increase your chances for addiction in the future, especially if taken early in life. Many patients find that there are other methods, such as ibuprofen and acetaminophen, as well as physical therapy, massage or acupuncture, to treat their pain and that they do not need opioid medications. Talk to your provider about other options for pain relief.

Take time to review the included patient information sheet and be sure to discuss any questions or concerns with your provider. Once you have been informed of the risks, please sign the bottom of this form.

I, \_\_\_\_\_, have been counseled by my provider and understand the risks associated with opioid use. I have been provided with information on the following:

- The potential of **misuse, abuse, diversion, and addiction** with opioid medication.
- **Side effects** including: feeling drowsy, constipation, sweating, itching, cloudy thinking, withdrawal upon discontinuation of use, mood changes (including worsening depression), sleep pattern changes (including worsening sleep apnea), and effects on hormones.
- Building up a **tolerance** – meaning having to take more medication to get the same pain relief effect.
- Life-threatening respiratory depression – meaning you can **stop breathing**.
- Accidental exposure can lead to potentially **fatal overdose, especially in children**. You must safely store your drugs to avoid accidental exposure or theft.
- Use while pregnant may cause **neonatal opioid withdrawal syndrome** in a newborn.
- **Combining opioids with alcohol and/or other psychoactive medication** can cause a fatal overdose. This includes, but is not limited to, combining with benzodiazepines and barbiturates.

I have also received a patient education sheet on opioids.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient's Parent, Guardian, or Legal Representative (if applicable)

\_\_\_\_\_  
Signature of Prescriber

**Disclaimer** This EXAMPLE informed Consent is provided by the Vermont Department of Health provided as an information resource only and is not to be used or relied on for any treatment or legal purposes. This information is not intended to be patient education, does not create any patient-physician relationship, and should not be used as a substitute for professional diagnosis and treatment. It does not constitute legal advice on the part of the State of Vermont. This information does not create an attorney-client relationship and is not a substitute for seek legal advice from an attorney or competent legal resource.

[Name of Facility]