Sample Hospice
Informed Consent for Treatment with Control Substances for Pain

Patient Name: _____ MR#_____

INSTRUCTIONS: this form is used to acknowledge receipt of the information herein and to confirm your understanding and agreement with its contents. Your signature below indicates that your practitioner has discussed all of the items below with you and you provide approval and understanding.

1. I understand that while my life may be prolonged for some period of time, but my health cannot be restored. My practitioner has advised me that during this period, care can be given to alleviate pain and suffering and efforts made to keep me comfortable.

2. My prescriber is prescribing pain medications, including controlled substances, for my condition. I have discussed with my prescriber a treatment plan established for me during this period including non-opioid, alternative means of treatment to alleviate my pain and to keep me comfortable.(§54(c/d))

3. When I take these medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing. (§54(b))

4. I have discussed with my prescriber and I understand the potential risks and benefits of treatment using controlled substances, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form. (§54(a))

5. I understand that when I take these medications, I may feel sedated, confused or otherwise impaired. During this time, I should not do things that would put me or other people at risk for being injured. (§54(b))

6. I acknowledge that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems. (§54(a/e))

7. I acknowledge that when I take these medications regularly, I may become physically dependent on them, meaning my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them 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. (§54(e))

8. I have discussed with my prescriber the proper use of the controlled substance prescribed. I understand that I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications. This may become relevant in the event that my condition improves sufficiently for me to discontinue hospice care for a time. (§54(e))

9. I understand that the hospice staff will provide pain medications as needed including refills. (§54(g))

10. I have discussed with my prescriber the methods to safely store and legally dispose of the controlled substance. I understand that prescriptions should always be stored in a secure place and out of the reach of children and other family member not assisting in my care. To safely dispose of unused medications, they can be disposed at a local pharmacy with a waste container, a local drug-take back day, a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera bag, which might be available for purchase at my pharmacy. (§54(f))

11. I understand that the opioid overdose antidote naloxone (Narcan®) is now available without a prescription. I may obtain naloxone (Narcan®) from a pharmacist without a prescription. (§54(i))

12. For Women**:** It is my responsibility to tell my prescriber immediately if I think I am pregnant.(§54(h))

13. If the patient is an unemancipated minor, as the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion. (§54(j))

By signing below, *I attest that I have reviewed this form with my prescriber and have had the chance to ask any questions regarding my treatment. I understand each of the statements written above and by signing give my consent for treatment of my pain with controlled substances.*

_____	_____	_____
Patient Signature/Power of Attorney	Patient/POA name printed	Date

If the patient is an unemancipated minor;

_____	_____	_____
Parent/ Guardian	Print name	Date