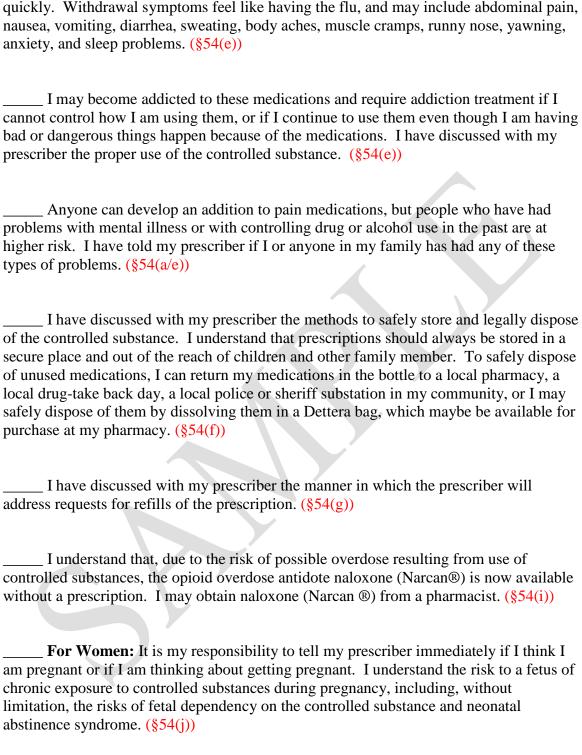
SAMPLE NEVADA WRITTEN INFORMED CONSENT CONTROLLED SUBSTANCE THERAPY FOR PAIN

Please review the information listed here and put your initials next to each item when you have reviewed it with your prescriber and feel you understand and accept what each statement says.

My prescriber is prescribing pain medications, including controlled substances, I ediscussed with my prescriber the important provisions of the treatment plan blished for me in a clear and simple manner. (§54(d))	
Every pain medication, including controlled substances, has different benefits and risks in the treatment of my symptoms. (§54(a))	
Before I was prescribed these pain medications, we discussed non-opioid, alternative means of treatment for my symptoms including	
· (§54(c))	
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))	
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))	
When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured. (§54(b))	
When I take these medications regularly, I will 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	



I have reviewed this form with my prescriber and have had the chance to ask any questions. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances.

Patient Signature	Patient name printed	Date
the prescriber the risks that	cipated minor, as the Parent/Guardian, I has the minor will abuse or misuse the contraction of the contracti	olled substance or
Parent/Guardian	Parent/Guardian name printed	Date