Patient Consent Form for Opioid Use

Consent for Opioid Use Under the Care of _____

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

I understand that I can discuss possible alternatives for this opioid prescription with my dentist 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 past/present drug and/or alcohol use.

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

- I am responsible for my medications and agree not to take them more frequently than prescribed and only if needed to manage pain. **I understand that increasing my dose without my dentist's knowledge could lead to severe sedation, respiratory depression and possibly even death**.

- I am responsible for my opioid medication and understand **opioids can cause severe sedation, respiratory depression and possibly even death if mixed with alcohol, other prescription medications and some over the counter drugs, such as Benadryl, sleep aids, etc.** Please ask your pharmacist when picking up this drug if there are **any** drugs you take that could cause problems while taking this medication.

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

- 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 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 others**.

- **I am 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 may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety and sleep problems.

- **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**.

- I understand I should store and secure 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.

Patient Name: _____ Date: _____

Signature of Patient, Parent or Guardian: _____