CANCER CARE SPECIALISTS
EXPERTS IN HEMATOLOGY AND ONCOLOGY

F. Craig Conrath, MD | V. Suresh Reddy, MD | Tejvir Singh, MD | Aaron T. Bowman, MD
John A. Shields, MD | Steven A. Schiff, MD | Sowjanya Reganti, MD | Margaret Van Meter, MD

INFORMED CONSENT FOR CONTROLLED SUBSTANCES:

I (Patient): _____
Condition to be treated by Controlled Substance: _____

Consent to Drug Therapy:

I hereby authorize and give my consent to my provider at Cancer Care Specialists to prescribe medications that are controlled substance(s) as part of therapy for my condition. The purpose of this consent is to ensure my safety while taking controlled substances and to ensure that myself and my provider are abiding by the federal laws established for controlled pharmaceuticals.

It has been explained to me that these medication(s) may include opioid/narcotic, muscle relaxants, anti-anxiety, insomnia, certain cough syrups, stimulants that treat some behavioral disorders, etc. drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. Alternative methods of treatment, possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED and understand that I will undergo medical tests or examinations before and during my treatment. Those tests include random unannounced checks for drugs on less than 24 hour notice and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in my being discharged from my physician's care.

For female patients only:
_____ To the best of my knowledge I am not pregnant.
initials

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I understand the possible side effects of medication(s) and that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use. If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

For ALL patients:
I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO:

1. Constipation
2. Nausea or vomiting
3. Excessive drowsiness or sleepiness
4. Itching
5. Urinary retention (inability to urinate)
6. Orthostatic hypotension (low blood pressure)
7. Irregular heartbeat
8. Insomnia (inability to sleep)
9. Depression
10. Impaired judgment &/or reasoning
11. Respiratory depression (slow or no breathing)
12. Impotence
13. Tolerance to medication(s)
14. Physical and emotional dependence, addiction and/or insomnia (inability to sleep)
15. Death

I UNDERSTAND that it may be dangerous for me to operate an automobile or other machinery while using the medication(s) and I may be impaired during all activities, including work.

The NRS Chapter 453C states “Opioid-related drug overdose” means a condition including, without limitation, extreme physical illness, a decreased level of consciousness, respiratory depression, coma or death resulting from the consumption or use of an

opioid, or another substance with which an opioid was combined, or that an ordinary layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.

I UNDERSTAND these symptoms should be treated emergently and an emergency response team must be notified so an opioid antagonist (or narcotic reversal medication) may be administered immediately if indicated.

The goal of this treatment is for the management of my condition in order to live a more productive and active life. The goal of taking a controlled substance medication(s) on an as needed basis or regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s) I understand that a referral to a pain specialist if all the prescribed interventions have been exhausted. My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue medication use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I UNDERSTAND that there is a risk of addiction with controlled pain medications. The State of Nevada defines addiction as follows: "Addiction is a neurobehavioral syndrome with genetic and environmental influences that result in psychological dependence on the use of substances for his/her mind-altering effects and is characterized by compulsive, habitual, or obsessive use despite harm. Addiction may also be called 'drug dependence' and 'psychological dependence.' **Physical dependence and tolerance** are normal physiological consequences of taking pain medications for extended periods of time and should **not** be considered addiction. "

Withdrawal symptoms such as a flu-like syndrome, irritability, diarrhea and muscle soreness are natural consequences of the abrupt discontinuation of pain medication. Therefore, if you and your provider decide to discontinue your pain medication(s), these medication(s) will need to be tapered off to avoid or diminish these withdrawal symptoms.

The long-term use of medications to treat my condition may be controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give informed consent.

PREFERRED PHARMACY:

Name: _____ Location:_____

Phone: (_____) _____Fax: (_____) _____

I certify and agree to the following:
I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

1. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of nontreatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.
2. I agree to waive my right to privacy and authorize my provider to discuss my medical care and use/misuse of medications with any health care provider, local emergency rooms and emergent care centers, legal authorities, pharmacies and the DEA.
3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____ _____

SIGNATURE **PRINT NAME** **Date**

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Controlled Substance Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking that are considered controlled substance. This is to help both you and Cancer Care Specialists to comply with the law regarding controlled pharmaceuticals.

- I understand the goal of this treatment is for the management of my condition in order to live a more productive and active life. The goal of taking a controlled substance medication(s) on an as needed basis or regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s) I understand that a referral to a pain specialist or behavioral therapist if all the prescribed interventions have been exhausted. My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue medication use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.
- I understand that if I break this Agreement, my doctor will stop prescribing these controlled substance medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. I will communicate fully the side effects or complications relating to the controlled substance that was prescribed.
- I will not use any illegal controlled substances, and I will not share, sell, or trade my medication with anyone. I agree to inform my Cancer Care Specialist provider of any alcohol, cannabinoid, or illicit drug use.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.
- I agree to inform my provider of any scheduled surgeries and/or procedures in a timely manner to allow any alterations of the medication(s) dosage.
- I agree that refills of my prescriptions for controlled substance medicine(s) will be made only at the time of an office visit. No refills will be available during evenings or on weekends.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood, saliva, or urine test if requested by my physician to determine my compliance of my treatment with pain control medication. Any necessary drug screening will be conducted by Timely Testing LTD, an independent professional provider of onsite drug and alcohol testing services. All costs associated with such testing will be paid for by Cancer Care Specialists and later billed to me as part of a routine office visit.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- Any unused, expired controlled substance medications must be surrendered to a local police department and other law enforcement facility to ensure lawful disposal.
- I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost, stolen, or damaged medication(s) and / or prescriptions may not be replaced.
- I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I agree to follow these guidelines that have been fully explained to me. Any and all of my questions and concerns regarding treatment have been adequately answered.

This Agreement is entered into on this _____ day of_____, _____.

Patient signature: _____

Staff signature: _____