Controlled Substances
High-Risk Consent and Planning Form

Patient name _____

Physician name _____

Date _____

After reviewing my opioid dosage and medical, psychiatric, and substance use history, my physician has informed me that I am at high risk for adverse events from the opioid prescription(s) that I am receiving for the management of pain. I understand that I am at significantly elevated risk of the following:

- **Opioid overdose, death and permanent disability**
- **Opioid addiction, also known as opioid use disorder**
- **Impairment from opioids, which may result in accidents or falls**
- **Hospitalization due to opioid-related complications (breathing difficulty, infection, trauma)**
- **Opioid side effects, including constipation, depression, hormonal imbalance, urinary problems, sedation, and depressed breathing**

My physician has explained their concerns regarding my risk of adverse outcomes and is committed to trying to decrease my risk while balancing the need to control my pain. My physician has suggested that I take several steps to reduce this risk; I am committed to following the recommendations below. **(Check all that apply.)**

- ☐ Exercise increased vigilance to **take my medications only as prescribed**, to not take additional doses, keep my medications in a secure location and not share my medications.
- ☐ I will fill a **naloxone prescription**, complete naloxone training, and inform my household members, family, and friends of my naloxone prescription, its location, and how to use it.
- ☐ I have been referred to a **pain specialist**, who has greater expertise in using opioids and controlling pain. I will make every effort to meet with this specialist.
- ☐ I will **taper my opioids** to a safer level.
- ☐ I will **transition from my current opioid to buprenorphine**, which has a better safety profile.

- ☐ I will modify my other medications, **decreasing or eliminating the use of other sedatives** like benzodiazepines, gabapentinoids, barbiturates, muscle relaxers, and sleeping aides.
- ☐ I will **decrease or eliminate the use of substances that may interact with opioids, including alcohol, marijuana, and sedatives**.
- ☐ I consent to **increased monitoring of my clinical condition and opioid medications**. This includes increased visits, drug screening, and other potential interventions as deemed appropriate by my physician.

I recognize my physician's concern and duty to emphasize my safety above all else. I understand my physician's desire to monitor my current medication regimen to avoid overdose, disability, and adverse outcomes. I recognize that opioids are a "controlled substance" and that my physician has the right to make changes or discontinue my medication if they believe that it compromises my safety.

Patient signature _____

This material was prepared by the Iowa Healthcare Collaborative, the Opioid Prescriber Safety and Support contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.

Developed in collaboration with Stader Opioid Consultants.