

USE OF CONTROLLED SUBSTANCES IN DENTAL TREATMENT

I, _____ understand and voluntarily agree that (initial each statement after reviewing):

*Patient's
Initials*

- _____ I have agreed to use controlled substances as part of my treatment plan to manage acute or postoperative pain or my dental condition.
- _____ I understand that the controlled substances being provided, where indicated, are useful in managing acute or postoperative pain, but have a high potential for addiction and/or dependence.
- _____ My dentist has informed me of nonmedication options to control my acute or postoperative pain.
- _____ I have been informed of the expected pain, intensity, duration, options, use of pain medication, nonmedication therapies, and common side effects.
- _____ I have been advised of the risks and benefits of the use of controlled substances, including the risk of abuse and addiction, as well as physical dependence.
- _____ I understand and accept that the most likely material risks and complications of controlled substance therapy have been discussed with me. Some of the risks and complications associated with the use of controlled substances are:
- Addiction or psychological dependence.
 - Breathing too slowly; overdose can lead to respiratory arrest and death.
 - Children born to mothers who have been prescribed opioids are likely to be born with physical dependence on the opioid.
 - Confusion or other alteration in thinking and alertness.
 - Decreased appetite.
 - Increased sleepiness or drowsiness.
 - Nausea.
 - Physical dependence; that is, stopping the medication abruptly may lead to withdrawal syndrome, characterized by one or more of the following: runny nose, anxiety, diarrhea, and abdominal cramping.
 - Problems with coordination and balance.
 - Urinary retention.
 - Constipation.
- _____ I agree to notify my dentist immediately if I suffer any complications or side effects from the use of the controlled substances.
- _____ I understand that I am responsible for my medications, and agree to take the medications as directed and not more frequently than prescribed. I understand that increasing my dose, taking my medications with alcohol, or combining the medications with other medications without my dentist's knowledge could all lead to drug overdose or drug interactions that could cause severe sedation and respiratory depression and possibly death or disability.
- _____ I understand that prescription medications that are lost, stolen, accidentally disposed of, or consumed before the appropriate date will not be refilled.
- _____ I understand that the controlled substance 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 that use of these medications with other medications not made known to my dentist could lead to overdose, death, or disability.
- _____ The dentist has answered all my questions regarding this treatment.

This form is for reference purposes only. It is a general guideline, not a statement of standard of care, and should be edited and amended to reflect current practice and individual policy requirements of your practice, the Centers for Medicare and Medicaid Services, and The Joint Commission, as applicable, as well as the specific legal requirements of your professional practice act.

I certify that I have read and understand this treatment agreement, and that all my initials were filled in prior to my signature.

I authorize and direct _____ DMD, DDS, to provide therapy using controlled substances.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the use of controlled substances to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

Dentist Signature/Date/Time

_____ Copy given to patient
Initials

_____ Original placed in patient's chart
Initials

11/18

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