

Patient Consent Form for Controlled Substance Use

Under the Care of _____ (Optometrist's name)

I have agreed to use controlled substances as part of my treatment for a condition of the eye and/or its appendages.

I have been informed that controlled substances including, but not limited to, narcotic pain medications, benzodiazepines and other hypnotic sedatives may be useful in my treatment but have a high potential for psychological addiction, physical dependence, or relapse of a prior addiction.

I have been informed of alternatives for this prescription, such as non-pharmacological and non-opioid therapy 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 drug and/or alcohol use.

Because my optometrist is prescribing a controlled substance in conjunction with my treatment, 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 my pain or other medical condition. I understand that increasing my dose without my optometrists' knowledge could lead to severe sedation, respiratory depression and possibly even death.
- ☐ Without prior disclosure to my optometrist, I will not request or accept controlled substance medication from any other healthcare provider or individual while receiving such medication from my optometrist.
- ☐ There are side effects with controlled substance 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 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 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 I should store 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

Signature of Patient, Parent or Guardian

Date