MUNSON HEALTHCARE

## START TALKING: CONTROLLED SUBSTANCES CONTAINING OPIOIDS

| Patient Name | Date of Birth |
|---|---|
| Name of Controlled Substance containing an Opioid | |
| Dosage | Quantity Prescribed (For a minor, if signature is not the parent or guardian, the prescriber must limit the opioid to a single, 72 hour supply) |
| Number of refills | |

**A controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse. My provider shared the following:**

a. The risks of substance use disorder and overdose associated with the controlled substance containing an opioid.

b. Individuals with mental illness and substance use disorders may have an increased risk of addiction to a controlled substance. (Required only for minors.)

c. Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drug that may depress the central nervous system can cause serious health risks, including death or disability. (Required only for minors.)

d. For a female who is pregnant or is of reproductive age, the heightened risk of short and long-term effects of opioids, including but not limited to neonatal abstinence syndrome.

e. Any other information necessary for patients to use the drug safely and effectively as found in the patient counseling information section of the labeling for the controlled substance.

f. Safe disposal of opioids has shown to reduce injury and death in family members. Proper disposal of expired, unused or unwanted controlled substances may be done through community take-back programs, local pharmacies, or local law enforcement agencies. Information on where to return your prescription drugs can be found at http://www.michigan.gov/deqdrugdisposal.

g. It is a felony to illegally deliver, distribute or share a controlled substance without a prescription properly issued by a licensed health care prescriber.

**I acknowledge the potential benefits and risks of an opioid medication as described by my provider along with the responsibility of properly managing my medication as stated above.**

| Signature of Prescriber (when prescribing to a minor) | Date | Time |
|---|---|---|
| Signature of Patient, if minor, patient's parent/guardian | Date | Time |
| Signature of Patient's Representative or other authorized adult | Date | Time |
| Printed Name of Parent/Guardian; Patient's Representative or other authorized adult | | |

**THIS FORM MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD**