OKLAHOMA DEPARTMENT OF CORRECTIONS

Consent for Pain Treatment with Controlled Substances
Inmate Agreement

Controlled substances medications (e.g. narcotics, benzodiazepines, and barbiturates) are useful for controlling both acute and chronic pain but have a high potential for abuse and addiction and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, and improve quality of life, function and/or ability to work.

Due to these medications having the potential for abuse or diversion (i.e. sharing, trading or selling), strict accountability is necessary for both medical safety and legal reasons.

By signing this form, I understand the following:

1. This agreement relates to my use of any and all medication(s) to manage my condition as prescribed by my health care provider.

2. I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

3. I will participate in all other types of treatment that I am asked to participate in.

4. I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

5. I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

6. I agree to undergo random urine drug testing at the discretion of the health care provider. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract.

7. I will communicate fully with my health care provider 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.

8. I understand and agree that failure to adhere to this agreement will be considered noncompliance and may result in cessation of controlled drug prescribing.

9. In this case, my health care provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms.

10. I have been given the opportunity to ask questions regarding the treatment with controlled substances. I have also been informed about alternative treatment, the risks and hazards associated with controlled drug treatment and the possible side effects that I may experience.

I hereby authorize and give my consent to accept the dangerous and/or controlled substance(s) (medication(s)) as part of therapy or treatment for my condition.

Inmate Signature: _____ ODOC # _____ Date: _____

Health Care Provider Signature: _____ Date: _____

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Inmate Name (Last, First) ODOC #