Richard Heidenfelder M.D.
Child, Adolescent and Adult Psychiatry

Patient Identification

Definitions: With respect to this document, the following terms will apply:

I (PATIENT): _____

MY PHYSICIAN: _____

CONTROLLED SUBSTANCE (MEDICATION): anxiety medications/stimulant medications/sleep medications

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

I voluntarily request my physician to treat my condition which has been explained to me
I hereby authorize and give my consent to administer or prescribe the prescription(s) for dangerous and/or controlled substance(s) (medication(s)) as part of therapy or treatment for my condition.

It has been explained to me that these medication(s) may include opioid/narcotic, anti-anxiety, insomnia, ADHD, etc. drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. Alternative methods of treatment, possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs on less than 24 hour notice and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in my being discharged from my physician's care.

For female patients only:

_____ To the best of my knowledge I am not pregnant.
initials

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I understand the possible side effects of medication(s) and that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use. If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

For ALL patients:
I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO:

1. Constipation
2. Nausea or vomiting
3. Excessive drowsiness or sleepiness
4. Itching
5. Urinary retention (inability to urinate)
6. Orthostatic hypotension (low blood pressure)
7. Irregular heartbeat
8. Insomnia (inability to sleep)
9. Depression
10. Impaired judgment &/or reasoning
11. Respiratory depression (slow or no breathing)
12. Impotence
13. Tolerance to medication(s)
14. Physical and emotional dependence, addiction and/or insomnia (inability to sleep)
15. Death

I UNDERSTAND that it may be dangerous for me to operate an automobile or other machinery while using the medication(s) and I may be impaired during all activities, including work.

The goal of this treatment is for the management of my condition in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I am expected to participate in a functionally restorative program that may include physical/occupational therapy and/or other psychological counseling as prescribed by my doctor. I understand that I may withdraw from this treatment plan and discontinue medication use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I UNDERSTAND that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat my condition may be controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give informed consent.

CONTROLLED SUBSTANCE AGREEMENT:

The following agreements are made between the Patient and Physician, as identified above, and outlines the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. This Controlled Substance Agreement relates to my use of any and all medication(s) to manage my condition as prescribed by my physician.

2. All medication(s) and prescriptions for the treatment of my condition will be obtained from only my physician.

3. Medication(s) for the management of my condition will be provided by my physician so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my physician's care and treatment.

4. Discharge from my physician's care and treatment may be immediate for any criminal behavior.

5. All medication(s) prescribed by my physician and other medication(s) prescribed by other physicians must be obtained at only one (1) pharmacy. I will provide my pharmacist with a copy of this agreement at the request of my physician.

6. I will use the medication(s) exactly as directed by my physician.

7. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my physician.

8. Use of illegal substances, alcohol, and other mood altering drugs can lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) at any time and without prior warning on less than 24 hour notice. Any evidence of use of illegal substances will lead to discontinuation of the medication(s).

9. My physician may at any time choose to discontinue the medication(s) for the treatment of my condition.

10. I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my physician.

11. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.

12. I will stop all other medication(s) for the management of my condition unless otherwise directed by my physician.

13. I agree to inform my physician of any scheduled surgeries and / or procedures in a timely manner to allow any alterations of the medication(s) dosage.

14. I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).

15. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.

16. I agree not to obtain or seek to obtain any other medication(s) from any other source (including Emergency Department, "urgent care clinic," etc.) without first contacting my physician. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of the medication(s) and treatment.

17. I understand that the State of tracks information provided by pharmacies regarding all controlled substance prescriptions. My physician may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.

18. I will notify my physician's office during office hours at least five (5) business days in advance before running out of medication(s) so the appropriate refills can be made.

19. I understand that refills will NOT be ordered before the scheduled refill date even if my medication(s) runs out. When traveling, arrangements may be made in advance of planned departure date.

20. If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of the medication(s).

21. I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., physical therapy, psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my physician to achieve increased function and improved quality of life.

22. I understand and agree that a consult with or referral to, an expert may be necessary such as submitting to a psychiatric or psychological evaluation by a qualified physician.

23. I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).

24. I must keep all follow-up appointments as recommended by my physician or my treatment and / or medication(s) may be discontinued.

Richard Heidenfelder M.D.
Child, Adolescent and Adult Psychiatry

Patient Identification

PREFERRED PHARMACY:

Name: _____

Location: _____

Phone: (_____) _____

Fax: (_____) _____

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of nontreatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.

3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

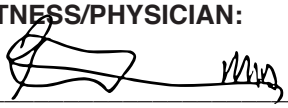
4. I agree to the use of the mediation(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

DATE: _____ TIME: _____ A.M. / P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____
Signature Print Name

WITNESS/PHYSICIAN:



_____ Richard Heidenfelder M.D.
Signature Print Name

_____
Address

_____
City, State, Zip code