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OPIOID ACKNOWLEDGEMENT

Michigan Department of Health and Human Services

(*Must Be Included In The Patient's Medical Record)

Michigan Department of Health and Human Services

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred 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:

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

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

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

4. 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.

5. 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.

6. 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

7. 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 patient, parent or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient: *

☐ SELF ☐ PARENT ☐ STEP PARENT ☐ GRANDPARENT ☐ GUARDIAN ☐ ESCORT ☐ OTHER

If Other than SELF, Please list First and Last Name:

_____

_____

Date: * _____

☐ * **I attest that I have discussed the risks, benefits, consequences with opioids with the patient (Or Representative) who had the opportunity to ask questions, and I believe my patient understands what has been explained.**

Signature of Doctor or Staff:

Signature _____ **Date** _____

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Authority: PCA 246 of 2017, MCL 333.7303b and MCL 333.7303c
Completion: Required
Penalty: Probation, limitation, denial, fine, suspension, revocation or permanent revocation

Response Date: _____