Pennyrile Family Dentistry, LLC

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Patient's Guide for Controlled Substances

Due to a new state law, your physician must take additional steps before prescribing certain controlled substances.

Your Dentist is required to obtain a **KASPER** (Kentucky All Schedule Electronic Reporting System) report on you prior to prescribing any controlled substance. KASPER is an electronic monitoring system that provides information on controlled substances you have been prescribed and had filled in Kentucky or other participating state pharmacies. Other requirements of the law include taking a medical history, performing a physical exam, and obtaining written consent.

Controlled substances can be used effectively to treat acute pain to allow you to recover from surgery, injury or other condition. This type of treatment rarely causes addiction. Medication should be discontinued when the condition is improved.

To reduce your chance of developing an addiction, you should take medications exactly as prescribed by your doctor. Also, be sure to let your doctor know of all other medications you are taking, including over the counter medications or herbal supplements.

You should also let your doctor know if you:

- Experience an increase in the amount of medication you need
- Are unable to limit or stop the medication use
- Experience withdrawal symptoms when stopping the medication (such as sweating, anxiety, nausea and vomiting, etc.) as these can be a sign of addiction.

Any unused medication may be taken to your local law enforcement office for disposal. You may also, in accordance with the FDA recommendations for disposal, remove the mediation from its original container and mix with an undesirable substance, such as used coffee grounds or kitty litter, then place in the household trash. Medications should not be flushed down the drains. When in doubt, you should speak to your pharmacist.

Consent for Treatment with Controlled Substances

I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits, and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate.

Also, by signing this consent, I am verifying that I am not receiving pain medication by any other provider that my doctor is not aware of. If it is determined that I am receiving pain medication from another provider, I understand there will be no future prescriptions written.

This consent is valid one calendar year from the date signed.

Patient Signature or Person Authorized to Sign for the Patient: _____

Printed Name: _____

Date: _____ **Time:** _____ _____

Patient SSN: _____ **DOB:** _____

Patient Address: _____

Pharmacy Name and Number: _____

Doctor: _____ **Witness:** _____