Opioid Usage Monitoring Consent Form

Date: ___________________________

Patient Name: ___________________________

Date of Birth: ___________________________

Dear [Patient's Name],

As part of your treatment plan, we need your consent to monitor your use of opioid medications. This monitoring is designed to ensure your safety and improve your treatment outcomes.

Please read the following information carefully:

Purpose of Monitoring:

To track your opioid usage and identify any potential issues related to your treatment.

What Monitoring Involves:

- Regular assessments of your prescription history.
- Urine drug screening as deemed necessary.
- Follow-up consultations to discuss your medication use.

Confidentiality:

Your information will be kept confidential and only shared with healthcare providers involved in your treatment.

Consent:

By signing below, you consent to the monitoring of your opioid usage as outlined above.

Signature: ___________________________

Date: ___________________________

If you have any questions, please feel free to ask.

Sincerely,

[Your Provider's Name]

[Your Provider's Contact Information]