**Vivitrol Program**

**Consent to Receive Vivitrol**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, want to stop using alcohol and/or opiate drugs such as heroin and morphine. Medical staff told me about a drug called Vivitrol that can help me stop using alcohol and/or opiate drugs by blocking my cravings for them and by blocking the high I get when I drink alcohol or use opiate drugs. **Staff gave me a Vivitrol Drug Information Acknowledgement and a Vivitrol Medication Guide written by the maker of Vivitrol.** I reviewed and signed the written materials. Staff explained the documents to me and gave me the chance to ask questions about those documents and Vivitrol.

I understand that I may die if I continue to use alcohol and/or opiates while I am taking Vivitrol. I understand that if I increase my use of alcohol or opiates while taking Vivitrol in order to get high, **I may overdose and die or be seriously injured**. I also understand that if I stop using Vivitrol and start using alcohol and/or opiates, my tolerance for those drugs may be less than it was, and that using the same amount of these drugs as I did before **could result in an overdose and cause my death**. I understand that I may not feel the usual effects of medicines containing opiates while on Vivitrol, including medicines for pain, cough and diarrhea, and that those medicines might not work for me. I agree to carry information to alert medical professionals that I am using Vivitrol so that medical personnel who may need to treat me in an emergency will know I am taking it.

I understand that if I have the following conditions I need to call 911 or immediately report to the nearest emergency room:

* Skin rash
* Swelling of the face, eyes, mouth or tongue
* Trouble breathing or wheezing
* Chest pain
* Feeling dizzy or faint
* Increasing depressive symptoms
* Thoughts of suicide

I understand that I need to tell my doctor or other medical person if I have any of the following conditions:

* Nausea
* Tiredness
* Headache
* Dizziness
* Vomiting
* Decreased appetite (not feeling hungry)
* Painful joints
* Muscle cramps
* Cold symptoms
* Trouble sleeping
* Toothache

I understand that I will receive a shot each time I am given Vivitrol. I also understand that I need to tell my doctor or other medical person if I have any of the following conditions after receiving a shot of Vivitrol, especially if they get worse over time or do not heal within 2 weeks:

* Pain where I received the shot
* A large area of swelling around the shot
* Blisters where I received the shot
* A dark scab where I received the shot
* The area where I received the shot feels hard
* Lumps where I received the shot
* An open wound where I received the shot.

***Staff has reviewed this information with me.***

*I understand that my participation in the Vivitrol Program is* ***voluntary****, and will not in any way affect my parole/probation status. I also understand that I may revoke this consent at any time with no effect to my parole/probation status.*

*Knowing everything stated above, I agree to participate in the Vivitrol pilot program in its entirety.*

Offender Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offender ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: The inmate received their 1st injection within the correctional facility in his/her

**LEFT** or **RIGHT** (**please circle one**) buttock. Their next injection must be in the opposite side (buttock) and must rotate each month.