**Tennessee Rheumatology Opioid Medication Contract**

* **I agree that I may be prescribed opioids (morphine-like drugs) as a part of my treatment plan for my inflammatory disease and that this contract will be valid while I am a patient at Tennessee Rheumatology.**
* I understand that these drugs may be useful but have a potential for misuse or dependency/addiction and are therefore closely controlled by the local, state, and federal government.
* Because my physician may prescribe an opioid medication as part of my treatment plan, I agree to the following conditions:
  1. **I am responsible for my medication**. I agree to take the medication only as prescribed.
     + I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation, respiratory depression, and death.
     + I understand that decreasing or stopping my medication without the close supervision of my physician may lead to withdrawal. Withdrawal symptoms may include but not limited to: yawning, sweating, watery eyes, runny nose, anxiety, tremors, muscle aches, hot/cold flashes, abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and may last up to 3 weeks.
  2. **I will not request or accept any other controlled substance medication from any other physician or individual while I am receiving such medication from my provider at Tennessee Rheumatology.**
  3. **I understand the side effects related to opioid medication.** Common side effects are nausea/vomiting, drowsiness, and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, and jerkiness. These side effects may occur at the beginning of my treatment and often go away within a few days. It is my responsibility to notify my provider of any side effects that continue or are severe (i.e., sedation, confusion, difficulty breathing).
  4. **I understand that I may not drive if I feel drowsy or confused.**
  5. **I am responsible for notifying my provider if I need to visit another physician or emergency room due to pain or if I become pregnant.**
  6. I understand that the opioid medication is **STRICTLY FOR MY USE ONLY** and I may be asked to show my medication at any appointment for a count of opioid medication.
  7. I understand that I must contact my provider before taking other drugs including but not limited to: Valium, Ativan, Soma, Xanax, Fiorinal, and Ezol; antihistamines such as Benadryl. Alcohol (beer, wine, or liquor) may produce profound sedation, respiratory depression, abnormal blood pressure, and even death while taking opioids.
  8. I will return to the clinic at least once per month for refills or as directed by my prescriber.
  9. I understand that my prescriptions will be sent electronically at each appointment.
  10. **I am responsible for my prescriptions.** I understand that refill prescriptions will not be made if I “run out early”, “lose a prescription”, or “spill or misplace my medication”. I am responsible for taking and keeping track of the amount of medication that I have. IF my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of the provider.
  11. **I agree to submit to drug screens** at any time as determined by my provider to detect any prescribed and non-prescribed medications.

I, \_\_\_\_\_     \_\_\_\_\_ have read the above information or it has been read to me, and all questions regarding a possible treatment plan that includes opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_     \_\_\_

Representative for Tennessee Rheumatology: \_\_\_\_\_\_\_     \_\_\_\_\_\_ Date: \_\_\_\_\_     \_\_\_\_