BRITISH COLUMBIA CENTRE ON **SUBSTANCE USE**
Networking researchers, educators & care providers

PATIENT AGREEMENT FOR TAKE HOME DOSING

In order to receive take-home doses of my medication, I, _____, agree to the following conditions to receive take-home (or "carry") doses.

- ☐ I am aware that the accidental ingestion of even a small amount of my medication by a child or other person who is not a regular user could result in overdose or death.
- ☐ I will store my medication in a safe, locked location that cannot be accessed by other people or by pets.
- ☐ I will not sell or share my medication with another person. I understand that doing so is dangerous and may lead to loss of access to take-home doses or removal from the program.
- ☐ I will provide a urine sample within 24 hours of being asked. If I do not provide a sample as requested, or illicit drugs are found in my sample, I may lose access to take-home doses.
- ☐ I will bring my medication to my clinic or pharmacy within 24 hours if asked to do so. If I do not, I may lose access to take-home doses and have to return to daily witnessed ingestion.
- ☐ I am aware that I need to always bring my medication to all of my medical appointments for assessment by clinic staff. If I do not do this as requested, I may lose access to take-home doses and have to return to daily witnessed ingestion.
- ☐ I understand that I must be able to meet the above requirements to receive take-home doses. If my situation changes and I can no longer meet them I may lose access to take-home doses.

Patient Signature: _____ Date: _____

Witness: _____

If applicable, I, _____ , agree to share responsibility
(Name and relationship)
for ensuring the above person's medication is taken as prescribed.

Witness: _____

This document was prepared with gratitude based on a template provided by Vancouver Coastal Health.

More information:
www.bccsu.ca

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