



Patient Information	
Surname: _____	Given name(s): _____
Date of birth: _____	PHN: _____

Patient Agreement
<p>I UNDERSTAND AND AGREE THAT:</p> <ul style="list-style-type: none"><input type="checkbox"/> I am being started/continued on methadone for the treatment of opioid addiction. While I may choose to taper off this treatment at any time, I understand that most patients benefit from at least one year of treatment or longer.<input type="checkbox"/> While I am receiving methadone treatment, I will only get opioid prescriptions from my methadone prescriber and will not get any from other doctors or clinics.<input type="checkbox"/> For my safety, I give consent to my methadone prescriber to communicate with my pharmacist and any other physicians involved in my care, and to check my PharmaNet profile.<input type="checkbox"/> I can expect confidentiality about my treatment from my doctor and other healthcare providers. My personal information will not be shared except with other healthcare providers as I agreed to above.<input type="checkbox"/> I will work with my methadone prescriber to develop a treatment plan and set goals. We will review regularly and change them as needed.<input type="checkbox"/> In addition to methadone, I can participate in counseling or peer-support groups and other programs as part of my treatment plan. My methadone prescriber will give me information about the options and programs available in my community.<input type="checkbox"/> I can choose my clinic and pharmacy and can decide to change either if necessary.<input type="checkbox"/> I can decide if I want to continue, stop or change my treatment plan at any time. I agree to make this decision with my prescriber.<input type="checkbox"/> Beginning methadone treatment will require daily trips to the pharmacy and regular visits to my prescriber, which may impact my work, school or other responsibilities.<input type="checkbox"/> My prescriber may need to make changes to my treatment plan to provide the safest and best possible care. These changes might include dosage, how often I pick up my medication, how often I visit the clinic, and how often my urine is tested. Until I am stable, I will receive methadone through daily witnessed ingestion at a pharmacy or another healthcare provider.<input type="checkbox"/> Once I am stable, my prescriber will work with me to determine if take-home doses are appropriate.

Patient Agreement (continued)

- If I am interested in take home dosing, my prescriber will require that I have:
 - At least 12 weeks of urine drug tests with no sign of cocaine, amphetamine, or other drugs
 - No alcohol or benzodiazepine use that is considered by my prescriber as unsafe with methadone
 - At least 4 weeks of receiving a stable methadone dose
 - Stability in my life including no missed appointments or doses, improved relationships with family and/or friends, or returning to work or school
 - Ability to safely store methadone at home (i.e., secure, locked containers or cabinets)
 - No signs of illicit drug use during the last 12 weeks
- I will not give my prescriptions or medications to anyone else.
- I will not take my medication more often or at higher doses than my prescription states.
- I am the only person who may pick up my methadone prescription from the pharmacy.
- Missing more than two doses of methadone may cause a loss of tolerance and may require that I take a lower dose until I stabilize, for my safety.
- If I do not pick up my methadone from the pharmacy for three or more days in a row, my prescription will be cancelled until my prescriber has been told the reason for my missed doses. I will be restarted on a lower dose of methadone after multiple missed doses to prevent overdose.
- Like any prescribed medication, the pharmacy cannot replace my medication if it is lost or stolen. I cannot pick my medication up early from the pharmacy.
- I will not be cut off from treatment. If methadone is not providing the results expected, my prescriber will work with me to try other medications. If my prescriber can no longer provide care for me, they will refer me to another person who can.

I UNDERSTAND THAT I AM EXPECTED TO:

- Provide urine for drug testing on a regular basis.
- Provide urine samples at the clinic and that these samples are not to be altered. Urine samples that are cold or appear to have been altered will be treated as a serious issue and may affect my treatment plan and ability to receive take-home doses.
- Avoid using alcohol or other drugs, such as prescription or over the counter opioid medications, sleeping pills, or tranquilizers. I understand that combining alcohol or these medications with methadone can lead to overdose and other serious harms and may affect my treatment plan and ability to receive take-home doses.
- Notify any health care provider that I receive care from that I am taking methadone.
- Do my best to keep appointments as scheduled. I understand that missing or skipping scheduled appointments may affect my treatment plan and ability to receive take-home doses.
- Treat others and be treated with respect. I understand that treating staff with disrespect for any reason is unacceptable and may lead to discharge from the program.
- Keep a Narcan (naloxone) kit on hand in case of overdose and receive training in how to use it.
- Notify my primary care provider if I become pregnant (if applicable)**
I understand that I must inform my prescriber if I am pregnant, suspect I may be pregnant, or if I am planning a pregnancy.

Patient Identified Goals	
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

Prescriber Agreement	
I confirm that:	
<input type="checkbox"/>	This form has been reviewed in detail with the patient and they understand its content fully. This should be reviewed again when the patient is not in withdrawal.
<input type="checkbox"/>	The patient was given time to ask questions and seek clarification before signing this document.
<input type="checkbox"/>	The evidence for other treatment options was reviewed, and the patient agrees to methadone.
<input type="checkbox"/>	Information and resources to support psychosocial treatment interventions and supports will be provided to the patient.
<input type="checkbox"/>	PharmaNet was reviewed to identify other prescribed medications, and will be checked at each subsequent appointment.
<input type="checkbox"/>	It is my responsibility to decrease the possibility of diversion. If and when the patient is assessed as ready to receive take-home doses, guideline standards for random urine drug tests and medication checks will be pursued and clinical judgement used in an effort to limit risks of diversion.
<input type="checkbox"/>	A treatment plan with clear goals was developed with the patient, and will be reviewed and documented regularly during treatment.

Consent	
Patient's signature: _____	Date: _____
Prescriber's signature: _____	Date: _____

