AHS- Rural Opioid Dependency Program Treatment Agreement (RODP)

Client Name: _____

1. I will only be prescribed Opioid Dependency Treatment after the RODP team has determined that I am a suitable candidate. I will present myself at my pharmacy in a state of withdrawal for initial dose of opioid dependency medication.

2. I agree to take medication as directed. I understand that when on opiate replacement therapy, taking any other narcotics such as Codeine, Morphine, Oxycodone, Fentanyl, Heroin and other substances **especially** alcohol and benzodiazepines such as Valium, Ativan, Clonazepam and others could be dangerous. These drugs may interact with opiate replacement therapy and cause overdose, coma or death. Stopping my opiate replacement therapy and restarting later at the same dose without medical direction could result in my death. Sharing my opiate replacement therapy with another person can cause their death.

3. I understand while my dose is being stabilized, I will attend a pharmacy every day and consume my medication under the supervision of a pharmacist.

4. I understand that I will become physically dependent on opiate replacement therapy, and will experience withdrawal symptoms if I suddenly stop taking the medication. For some patients opioid dependence therapy is a long term treatment.

5. I understand opiate replacement therapy may cause drowsiness, especially when starting treatment, or when I receive dose increases. As a result, this may impair my ability to operate a motor vehicle. If I experience sedation, it is my responsibility to inform the RODP team.

6. For safety reasons, the RODP treatment team may communicate with any physician or pharmacist who has recently provided care to me, to ensure each is fully aware of treatment being provided by the other.

7. I agree that when I see another doctor or dentist, I will inform them I am taking opiate replacement therapy. I agree to provide copies of any prescriptions for review to the RODP team. I understand that in certain cases, the RODP physician may not be comfortable prescribing opiate replacement therapy in combination with other medications.

8. I consent to the release of my information to other service providers directly involved in my treatment. However, I am aware that if RODP staff have significant concerns for my safety or the safety of others that they may release my information.

9. I may be granted a limited number of take home doses “carries” of opiate replacement therapy once I have demonstrated that I am clinically stable through my presentation at appointments with pharmacy staff and with negative urine drug samples. Once obtained, carries will be suspended with any concern or evidence of clinical instability. It is a “carry” requirement that I have a safe storage spot in my home to avoid accidental ingestion, theft, or misplacement. Please note: lost doses will not be replaced.

10. I am aware that there are other treatment options. I am also aware that counselling and other addiction services are available in the community to help. For increased success in the program, it is recommended that I connect with Addiction & Mental Health Services. (ODP team members can assist in finding connections as close to home as possible).

11. I agree to behave in a respectful manner towards all RODP team members, Telehealth site staff, community partners, such as pharmacists and laboratory staff and other community members. I understand that any violence, threats of violence, verbal abuse or disruptive behavior will not be tolerated and will likely result in my termination from treatment.

12. I understand that my dose may be decreased or even stopped if the RODP team determines that the risks associated with opioid maintenance therapy are exceeding the benefits of treatment. Involuntary withdrawal from opiate replacement therapy may be more rapid if it is indicated for my safety or the safety of others.

14. I consent to have my photo taken for identification purposes, related to my treatment with ODP.

15. Rural ODP will use non identifiable patient information for research and quality improvement exercises in accordance with AHS policies and procedures.

16. It is my responsibility to be aware that my prescription is coming due and that I will take the appropriate steps (ie make an apt with my doctor) to get it filled.

Staff: _____ **Date:** _____