Client Agreement for Methadone Treatment

Client Name _____

Heath Record # _____

The prescribing and dispensing of methadone is regulated by provincial and federal guidelines, as well as by policies unique to Dr. Datema. The purpose of this contract is both to inform you about methadone maintenance therapy and to document that you agree to the rules and obligations described in this agreement.

Acknowledgments

I acknowledge the following:

1. Methadone is an opioid (opioids are drugs like heroin, codeine, morphine, Percocet, etc.). Taking it will result in physical dependence on this medication. Sudden decreases in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.

2. I am already (before beginning methadone treatment) physically dependent on at least one form of opioid and have been unable to discontinue the use of opioids.

3. I have tried to the best of my ability other possible treatments for opioid dependence, and these attempts have been unsuccessful.

4. Taking any mood-altering substance with methadone can be potentially dangerous. There have been reported deaths caused by combining methadone with alcohol, opioids, cocaine, barbiturates and/or tranquillizers (such as Valium, Ativan, etc.).

5. I may voluntarily withdraw from the methadone treatment program at any time.

6. I must inform any physician or dentist who prescribes an opioid for me that I am on methadone. I understand that not doing so is considered “double doctoring,” which is a criminal offense.

7. Regarding pregnancy, I understand that methadone can have effects on a developing fetus, and that specialized care will be required to reduce any harm to my fetus if I am or become pregnant while on methadone. I acknowledge that I may need to be transferred to another clinic in this case.

8. It may be unsafe to drive a car or other motor vehicle, or to operate machinery, during the stabilization period after starting methadone and during dose adjustments.

9. Poppy seeds and certain over-the-counter medications may result in positive drug urine screens.

10. The common side effects of methadone are sweating, constipation, decreased sexual function, drowsiness, increased weight, and water retention. These are usually mild and can be lessened with help from a doctor. Many of these side effects

will go away on their own in time. There are no known serious long-term effects from taking methadone.

11. This clinic's doctor is not my family doctor. I need a family doctor while I am on the program, to deal with medical problems not related to methadone maintenance. I understand that the clinic's physician will not be able to help me with ODSP forms, non-methadone prescriptions or notes for work (unless they are directly related to being on methadone).

12. It is my responsibility to make and keep appointments at the clinic and to make sure that my methadone prescription does not run out.

13. Methadone treatment will be stopped if my physician determines that it has become medically unsuitable, for example, because the treatment is not effective or because I develop a medical condition that could be made worse by taking methadone.

Behaviour While in The Clinic

I understand that the following behaviour is not acceptable:

1. Any violence or threatened violence directed toward the clinic staff or other clients.

2. Disruptive behaviour in or near the clinic.

3. Any illegal activity, including selling or distributing any kind of illicit drug in or near the clinic.

4. Any behaviour that disturbs the peace in or near the clinic.

I agree to maintain positive, respectful behaviour toward staff and other program clients at all times when in the clinic. Threats, racist or sexist remarks, physical violence, theft, property vandalism or mischief, possessing weapons and selling or buying illicit substances while in or near the clinic are extremely serious program violations that may result in the termination of my treatment.

Obligations of Being on This Program

1. I agree to pick up my medication during pharmacy dispensing hours, and to take the medication according to the pharmacist’s directions.

2. I understand that there is a dispensing fee for every dose of methadone that I receive from the pharmacy. If I have coverage for drug costs from private insurance or social services, I will provide the needed paperwork for my plan. If not, I understand that I will be responsible for paying this fee every time I receive a dose. If I do not make this payment, the pharmacy will not fill my prescription.

3. If I have my methadone paid for at the pharmacy by a third party, I agree to present my drug card in a timely manner to the pharmacy each month.

4. It must inform any physician or dentist who treats me for any medical or psychiatric condition that I am receiving methadone, so that my treatment can be tailored to prevent potentially dangerous interactions with methadone. I will bring the

prescriptions and/or bottles for any medications I am prescribed to my appointments and to the pharmacy where I get my methadone to check for any potential drug interactions.

5. I agree to provide a supervised urine sample when requested by program staff. If I refuse to provide this sample, the result may be that I do not receive take-home methadone doses ("carries").

6. If I do not provide a urine sample, my record may be marked that this sample was assumed to contain drugs. This could further affect my level of carries.

7. I understand that tampering with my urine sample in any way is a serious violation of the program, and it may affect my future status in the program.

8. I agree to have non-harmful clinical marker placed in my methadone from time to time, to ensure that I am taking my methadone and providing valid urine samples.

9. I agree to meet with a counsellor for an initial assessment that will be used to help me develop a personal action plan based on my specific needs and goals. I understand that it is recommended to meet with a counsellor at least every three months after this for a follow-up.

10. I agree to keep all my appointments with the physician who is prescribing methadone for me. I understand that if I miss appointments repeatedly, this may result in the reduction of my "carry" level and could interfere with the doctor-client relationship.

Grounds for Refusal of a Dose

I understand that I will not be given a dose of methadone in the following situations:

1. If I appear to be intoxicated or under the influence of some other substance. (I may also be requested to see a physician in this case. For the sake of my own physical safety, I may be asked to wait before receiving my dose, or refused a dose for that day.)

2. If I arrive late, after the end of the clinic or pharmacy hours.

3. If I exhibit threatening or disruptive behaviour toward any staff member or another client.

4. If I do not show proper identification before receiving methadone.

5. If I miss more than three doses of methadone in a row. (To re-start treatment at this point, I would need to be seen by a physician.)

Take-Home Methadone Dose ("Carries")

1. Methadone is a potent medication. A single dose taken by a patient not used to taking opioids, especially a child, can be fatal. For this reason, I agree to store take-home dose(s) in a locked box, in a place where they are unlikely to be stolen or accidentally taken by another person. An ice pack may be included in the box to keep the orange juice fresh.

2. I agree that the number of take-home doses I receive will be decided by my physician, with input from therapists, nurses and pharmacy staff, as I progress in my treatment.

3. I agree not to give, lend or sell my take-home doses to anyone.

4. I agree that I will consume the methadone on the dates specified on the medication label and in the appropriate manner—that is, a full dose is taken within 24 hours.

5. I agree to return all empty methadone bottles on my next day back at the pharmacy after receiving any take-home doses.

6. I understand that take-home doses will *only* be given if I leave urine screens according to the schedule arranged with my doctor, and that if an appointment is missed and a prescription is sent to my community pharmacy directly, it may not include my take-home dose(s).

Consents

1. I allow my physician to report to the College of Physicians and Surgeons of Ontario (CPSO) my name, date of birth, OHIP number and city of residence, and the date my methadone treatment will begin. The CPSO will keep the information confidential. This reporting is to prevent double doctoring and is mandatory for starting MMT.

2. I allow the CPSO, or its' designate, permission to review my chart. The purpose of this review is to assess the care provided by my physician; it is not meant to judge my recovery.

3. I allow my methadone prescribing physician or dispensing pharmacist to speak to other health care professionals about my care.

4. I allow the pharmacy and nursing staff to speak to other health care providers to verify any recent methadone dose(s) that I received at another pharmacy or institution.

Confidentiality

I understand that everything that I tell the clinic staff is confidential except under certain exceptional circumstances, when the clinic staff must report something to the appropriate authority:

1. If staff suspect that a child is at risk of emotional or physical harm or neglect, they are obligated under the Child and Family Services Act to report this information.

2. If I become suicidal, homicidal, or are unable to take care of myself due to a psychiatric condition including substance dependence, I may be held against my will in order to be assessed by a psychiatrist.

3. If I reveal to the staff that I intend to harm another person, they are obliged to protect that person by notifying the appropriate authority.

4. If a court subpoenas my chart, the clinic must release it.

5. If it is suspected that I am unable to drive a car due to a medical condition (which includes intoxication from alcohol or drugs), the clinic is obliged to notify the Ministry of Transportation of this and may confiscate my car keys.

6. Certain infections must be reported to the local public health unit. Examples include tuberculosis and HIV.

I also agree to respect the confidentiality of other clients in the program.

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. I understand that, if I fail to meet my responsibilities as a participant in this agreement, I may be discharged from the methadone program.

I have had an opportunity to discuss and review this agreement with my attending physician and any questions I had have been answered to my satisfaction.

_____
Date (dd/mm/yyyy)

_____	_____
Client (print name)	Witness (print name)
_____	_____
Client Signature	Witness Signature

**A copy of the signed agreement must be given to the client.*