# Agreement to Methadone Maintenance Treatment

**This is an agreement for methadone maintenance treatment between**
**_____ and_____**

***(Patient/Client)*** **(*Physician/Clinic)***

1. I understand that the methadone maintenance doctor will perform an assessment and medical examination, will establish the diagnosis of an Opioid Dependence Disorder, and will prescribe methadone, if it is considered appropriate and safe for me.
2. I agree to take methadone under medical direction, to assist me in dealing with my opioid dependence. I have tried or considered other treatment options. I understand that methadone maintenance is generally a long-term treatment.
3. I understand that I will become physically dependent on methadone and will experience withdrawal symptoms if I suddenly stop taking it.
4. I understand that methadone may cause drowsiness especially when starting treatment or when I receive increases in my dose. As a result, this may impair my ability in operating motor vehicles.
5. I am aware that the methadone maintenance treatment team may consist of several professionals including doctors, pharmacists, nurses, counsellors, social workers and support staff, who will be in close communication with each other to assure safety in my care.
6. For safety reasons, the methadone doctor will contact my doctor in order to ensure that each is fully aware of the treatment being provided by the other.
7. I recognize that counselling and other addiction assessments are available to assist me in dealing with the psychological and social difficulties that can accompany problems of opioid dependence.
8. I understand that when on methadone, taking other narcotics (e.g. Tylenol # 1,2,3, or 4, codeine, morphine, oxycodone, hydromorphone, fentanyl) and/or other substances, especially alcohol and benzodiazepines (Ativan, Lectopam, Restoril, Rivotril, Serax, Valium, Xanax) could be dangerous, especially if taken in excess. They may interact with methadone and cause overdose, coma, or even death.
9. I agree that when I see another doctor or dentist I will inform them that I am taking methadone. I agree to provide copies of any prescriptions obtained by me for medical reasons to be reviewed by the methadone maintenance doctor. The treatment team, if necessary, may do follow up with the prescribing doctor. I understand that in certain cases, the methadone prescribing doctor might not feel comfortable in prescribing methadone to me in combination with other medications that I have been prescribed.
10. I understand that initially I will be required to drink my methadone daily under the direct observation of a pharmacist or other qualified health care professional. Even after carry privileges have been granted (see # 11 below), I will still be required intermittently to drink a dose of my methadone under direct pharmacy or health care supervision.

11. I am aware that I may be granted a limited number of take-home carries of methadone once I have demonstrated sufficiently that I am no longer continuing to use illicit and/or other non-prescribed drugs and have made obvious positive and stable life-style changes. Carries may also be considered for specific reasons such as work/school. Carry privileges may not be provided if I miss clinic or medical appointments, not provide urine samples for toxicology testing when requested, misuse or divert my carries, as examples.
12. I realize that methadone can be fatal to others and will keep any methadone in my possession secure.
13. I understand that I must satisfy the doctor prescribing methadone for me that I have made all necessary arrangements to ensure the safety of myself and others, where carries are involved. This may include transporting and storing carries in a locked box or other secure container.
14. I realize that if I use my carries inappropriately, further carries will be suspended.
15. I understand that missed doses will be recorded on my file and will result in actions to ensure my safety. These may include a reduction or suspension of my dosage until I am reassessed.
16. I understand that the College of Physicians and Surgeons of Alberta, Triplicate Prescription Program monitors methadone prescriptions, and as such my prescription information will be recorded. This may involve occasional review of my file by an external reviewer, to ensure that my medical treatment is delivered in a safe fashion. None of the information on my file will be given to anyone outside this review process.
17. I understand that all clinical information on my file is confidential and will not be released to anyone without my written consent, except where staff believes there is a medical emergency and intervention is required by clinic staff and/or other persons.
18. I agree to attend ongoing medical examinations, urine drug testing, other laboratory testing, and counselling appointments when required.
19. A witnessed collection of urine may be required in the following examples: an invalid sample based on its temperature, results or repeated missed appointments for the required urine drug testing.
20. I agree to behave in a respectful manner towards all treatment team members and other patients/clients.
21. I understand that any violence, threats of violence, verbal abuse or disruptive behaviour, or diversion of my methadone will not be tolerated and could result in my termination from treatment.
22. I understand that my dose may be decreased and then stopped if it is determined that I am not benefiting from methadone maintenance treatment. Involuntary withdrawal from methadone may be more rapid if it is medically indicated for my safety or the safety of others.

**The undersigned fully understands the conditions of the agreement, agrees to the provisions in full and has received a copy of this document.**

_____
(Patient/client) signature

_____
Date

_____
Witness signature

_____
Date