Sample Methadone Maintenance Treatment Agreement from CPSO

The prescribing and dispensing of methadone is regulated by provincial guidelines, as well as policies unique to Dr. ____________’s practice. This contract has been prepared to both inform you about methadone maintenance therapy, as well as to document that you agree to the rules/obligations contained in this agreement.

MMT Program Rules
It is important that the patient receive clear information about the MMT program rules and expectations. Policies on take-home doses, urine drug screens, appointments, and treatment withdrawal should be specified. The MMT physician should provide a copy of the treatment agreement to the patient and revisit it once the patient is stabilized.

Acknowledgments:
I acknowledge that:
1. Methadone is an opioid (opioids are drugs like heroin, codeine, morphine, Percocet, etc.), and that I will develop a physical dependence to this medication. Sudden decreases in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.

2. I am already physically dependent on at least one form of opioid and I’m 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 the combination of methadone with alcohol, opioids, cocaine, barbiturates, and/or tranquillizers.

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

6. It is important to inform my physician/dentist who is prescribing an opioid that I am taking methadone. I understand that a failure to do so is considered double doctoring, which is a criminal offence.

7. Regarding pregnancy, I understand that there can be effects on the developing fetus caused by methadone, and that specialized care will be required to reduce any harm to my fetus if I am or become pregnant while on methadone.

8. It is unsafe to drive a motor vehicle or operate machinery during the stabilization period after starting methadone and during dose adjustments.

9. Poppy seeds and certain over-the-counter medication may result in a positive drug UDS drugscreen screen.
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 assistance from my doctor. There are no known serious long-term effects from taking methadone.

11. I acknowledge that Dr. _______________ is not my family doctor.

12. Methadone treatment will be discontinued or tapered if my physician determines that it has become medically unsuitable (i.e., the treatment is not effective or I develop a medical condition that could be made worse by methadone administration).

**Behaviour while in our clinic**

I understand the following behaviour is not acceptable in the clinic and may result in the termination of treatment:

1. Any violence or threatened violence directed toward the staff or other patients.

2. Disruptive behaviour in the clinic or the surrounding vicinity of the methadone clinic.

3. Any illegal activity, which includes selling or distribution of any kind of illicit drug in the clinic or the surrounding vicinity of the methadone clinic.

4. Any behaviour that disturbs the peace of the clinic or the surrounding vicinity of the methadone clinic.

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

**Obligations of being on this program**

1. I agree to take only one dose of methadone a day, and to have the ingestion of my dose witnessed on those days that I don’t have carries (take-home methadone).

2. It is important to inform any prescribing physician or dentist who may treat me for any medical or psychiatric condition that I am receiving methadone, so my treatment can be tailored to prevent potentially dangerous interactions with methadone. I will bring any prescriptions and/or medication bottles that I receive from other doctors to appointments with Dr._____________.

3. I agree to provide a supervised UDS drug screen sample for a drug screen when I receive a prescription for methadone.

4. Failure to provide a UDS drug screen sample may mean that my record will be marked as a sample assumed to contain drugs and that this could reduce my level of carries.
5. I understand that tampering with my UDS drug screen sample in any way is a serious Violation of the program, and it may affect my future status in the program.

6. I understand that counselling is highly recommended while I am in the program.

7. I agree to keep all my appointments with the physician who is prescribing methadone for me. Repeatedly missing appointments may result in the reduction of my carry status and could interfere with the doctor-patient relationship. The physician is not obligated to fax a methadone prescription without an assessment.

I understand that I will not be given a dose of methadone if I:

1. Appear to be intoxicated or under the influence of some other substance. I may be asked to see a physician. 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. Arrive late, after the clinic/pharmacy hours.

3. Exhibit threatening or disruptive behaviour towards any staff member or another patient.

4. Do not show proper identification before receiving methadone, if asked for identification.

5. Miss more than three doses of methadone in a row.

Consents

1. I allow my physician to report to the CPSO of Physicians and Surgeons of Ontario (CPSO) my name, date of birth, OHIP number, city of residence, and the date methadone was initiated. The CPSO will keep this information confidential. This is done to prevent double doctoring.

2. I allow the CPSO or its designate permission to review my medical chart. This is done to assess the care provided by my physician and is not meant to judge my recovery.

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

4. I allow the clinic’s pharmacist and nursing staff to speak to pharmacists or other health care providers to verify my recent methadone dose(s), which I received in another pharmacy or facility.

Confidentiality

Everything that you tell the clinic staff is confidential, although it is important to realize that under exceptional circumstances we can be obliged to report something you tell us to the appropriate authority. This can occur under the following conditions:
1. If we suspect that a child is at risk of emotional or physical harm or neglect, under the Child and Family Services Act, it is the law that we report this information.

2. If you become suicidal, homicidal, or are unable to take care of yourself due to a psychiatric condition, you might be held to be assessed by a psychiatrist against your will.

3. If you reveal to the staff that you intend to harm another person, we will be obliged to protect that person by notifying the appropriate authority.

4. If a Court subpoenas your medical chart, we must release it in accordance with the subpoena.

5. If it is suspected that you are unable to drive an automobile due to a medical condition (which includes intoxication from alcohol or drugs), we are obliged to notify the Ministry of Transportation of this.

6. Certain infections must be reported to the local public health department, e.g., tuberculosis, HIV.

*I agree to respect the confidentiality of other patients in the program.* My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that I may be asked to leave the methadone program.

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

________________________________________
Dated (dd/mm/yyyy) Patient’s Name Patient’s Signature

________________________________________
Dated (dd/mm/yyyy) Physician’s Name Physician’s Signature