Buprenorphine is a special medication which has proven to make life better for many people. We would like to congratulate you on what we hope will be the start of a successful journey.

You have made a decision with your provider that Buprenorphine may be a helpful medication for you, and we want to be clear in what you can expect from us, and what we expect in return.

**Patient and Provider/Team Agreement:**

1. Your care team at Clinic X Health Center is committed to treating you with the respect and dignity you deserve. We ask that you give us the same in return.
2. We believe that honest and transparent communication is the cornerstone of safe and effective medical care. Our care team is committed to serving you with honesty and transparency. We ask that you do the same in return.
3. For patients taking Buprenorphine, having support is helpful and important. We ask that you meet with a member of our Behavioral Health team in order to collaboratively develop an individualized support plan.
4. We agree that your provider may stop prescribing the medication or you may decide to stop taking the medication if there is no improvement in your function, if there is no sign of improvement from the medication, if there are significant side effects from the medication, or if the medication is proving to be an unsafe treatment option for you.

**Provider/Team Commitment to Patient:**

We are making a commitment to working with you in your efforts to improve your health. To help you we agree that:

* We will protect your privacy.
* We will attend to all aspects of your health.
* If we have to change your appointment, we will make sure you have enough medication to last until your next appointment.
* We will work with you to ensure this treatment is as safe and effective as possible.
* We will help you set treatment goals and monitor your progress in achieving these goals.
* We will support you in staying on track with your individualized care plan.
* We will work with other medical or mental health providers that you are seeing and provide them with information on buprenorphine so they can safely and effectively treat you.
* We will work with you when and if you feel it is time to begin decreasing your medication and decrease the dose slowly to minimize withdrawal symptoms and ensure your success in tapering off of the medication.
* Explain the meaning of test results or specialty visits/consultations, and what can be expected in the future.
* Explain the risks, benefits, side effects and limits of medication assisted treatment and proposed treatments.
* Provide you with written notice of risk.
* Respect your right to participate in making treatment decisions, including the right to refuse some types of treatment.
* Make sure that you have access to acute care and pain management when medically appropriate (broken bones, acute injury, recovery from surgery) even when I am not personally available.
* If for some reason you are not able to remain on the buprenorphine program, we will work with you to find other treatment, and, as best we can, work with you to make sure you do not have a lapse in medical care.

**Patient Commitmen**t

In order to receive my Buprenorphine prescription, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_will:

* Share changes in my medical care, and I agree that Clinic X will be the only prescriber of my Buprenorphine medication.
* Be willing to learn new ways to manage my social and mental health stressors by attempting step-by-step behavior and lifestyle changes in my daily life.
* Provide a urine sample in a timely manner. (Urine drug screens (UDS) are used as one indicator of whether or not Buprenorphine is an appropriate medication for patients. UDS will be unscheduled and random.)
* Take my medication as directed by my provider and make my medication last until the next scheduled appointment.
* Never give or sell my medications to someone else.
* Understand that lost or stolen prescriptions or medications may not be refilled.
* Make no changes to the dose or how the medication is taken without first talking to a member of my medical team.
* Not use other medications or drugs that are likely to interfere with this treatment as indicated and discussed with my provider.
* Inform all of my medical providers of the medications I am taking.
* Arrange for refills only through my medical team during my regularly scheduled appointments, unless we make other arrangements.
* Use one pharmacy for all of my medications. Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* Protect my prescriptions and medications, keeping all medication away from children.
* Have a working phone number where clinic staff can reach you within 24 hours. That number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* Inform my clinic of my most up to date contact information to reach me. I will call the clinic to update my file with any changes to my emergency contact, address, phone number or insurance coverage.
* Fill a prescription of naloxone and have a family or friend trained on how to administer in case of an accidental opioid overdose

This confirms that I asked you if you wanted a more detailed explanation of our patient/provider relationship and responsibilities (check one):

* **Are satisfied with that explanation and desire no further information.**
* **Requested and received, in substantial detail, further explanation of the patient/provider** **relationship and responsibilities, and/or risks and side effects of treating your condition with Buprenorphine.**

If this information accurately represents our discussion, and if you are satisfied with the explanation given, please sign this document indicating your agreement to the terms of our patient/provider relationship and responsibilities, and your consent to the use Buprenorphine for your medical condition.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information about Buprenorphine Treatment**

1. Buprenorphine is a medication used to treat people with dependence to opioids such as heroin, oxycodone or hydrocodone. Buprenorphine is an opioid that can be used to replace the drug(s) you are using, to prevent withdrawal sickness and help you stop using them.
2. Your body will get used to taking buprenorphine and you will get sick (withdrawal) if you stop it suddenly. For that reason, we maintain patients at the lowest effective dose, usually 16mg daily or less.
3. Buprenorphine should be taken as instructed by your medical provider.
4. If you take this medicine while there are high levels of opiates or opioids such as heroin, OxyContin, or methadone in your body you may have severe withdrawal symptoms.
5. Buprenorphine works only if dissolved completely under the tongue; it will not work as well if you swallow it and can be dangerous if taken other ways.

1. Buprenorphine may make you constipated or tired or cause a rash. If you have any side effects from the medicine, notify your doctor.
2. Buprenorphine may cause damage to the liver; this is uncommon. Blood tests can be done to see if symptoms are happening. This is more common with Hepatitis C.
3. Buprenorphine treatment is flexible and can last as long as needed to help prevent relapse. You and your provider will discuss how long you should be in treatment. When you and your provider agree to begin a decrease in buprenorphine, the dose will be decreased slowly to help prevent withdrawal.
4. There are serious risks to taking buprenorphine with alcohol or medicine that causes sleepiness. Benzodiazepines such as Klonopin, Valium, or Xanax may be dangerous or deadly for people on buprenorphine. This can lead to abuse and relapse. These medications will only be allowed when taken as prescribed by a medical provider or psychiatric consultant with no signs of abuse or unsafe behaviors.
5. Buprenorphine changes how opioid medications react in your system. You must notify all medical professionals caring for you that you are taking this medication. You must notify the treatment team immediately if you need to have surgery or any medical procedure so we can plan ahead for pain medication.
6. This medication has some risks as well as benefits for women who are pregnant. Women who are pregnant generally require a different form of medication. If you are pregnant or considering getting pregnant, please notify the treatment team.
7. Buprenorphine treatment is not the right treatment for everyone. If the treatment team decides this is not the right treatment for you, we will provide you with resources for other types of treatment options.
8. Buprenorphine is prescribed for you and should not be taken by others who are not prescribed Buprenorphine. Buprenorphine must be kept out of the reach of children and should be locked up in a cabinet or lock box if you live in a household with children**. If a child takes your buprenorphine, you must call 911 immediately.**
9. For patients taking Buprenorphine, having support is helpful and important. Patients are required to meet with a member of our Behavioral Health team in order to collaboratively develop an individualized support plan that could include but is not limited to an agreement to engage in counseling, groups and/or 12 step programs, etc.

I have read this form and discussed it with a medical provider or member of the treatment team. I have had the opportunity to ask questions with the providers on the treatment team.

\_\_\_\_\_\_\_ I would like to begin Buprenorphine treatment

\_\_\_\_\_\_\_ I would like resources to a different type of treatment program

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**Treatment Team Statement**

I have reviewed the information above with the patient and believe they understand what Buprenorphine treatment consists of including possible risks, side effects and benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Buprenorphine Treatment Team Member Signature Date

By signing below, I have read and understand this agreement.



**SIGNATURE (Patient, Guardian or Person Authorized to Sign for Patient): NAME Please Print Date**



**SIGNATURE (Provider): NAME Please Print Date**

NOTE: If other than Patient or Parent, PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED in the form of a custody order, guardianship order or medical power of attorney.

|  |  |  |
| --- | --- | --- |
|  | Health Centers Division | Patient ID |
| **Buprenorphine - Patient Agreement** | Name  |
|  | DOB  |
| Scan under CONSENTS | MRN  |