Government Logo

FORM 1A VER. APR. 2023

MEDICALLY ASSISTED THERAPY

CLIENT CONSENT FORM

Client Information

Date: 04/12/2025

Name of Client: HARTMAN ALULU ALULU

MAT ID: 10507MAT0927

Sex: Male

CSO: CSO - LVCT

Client Declaration

I HARTMAN ALULU ALULU of telephone number _____ and ID number

(where the client is under the age of 18 years, state the age of the patient) Age: _____

and accompanied by _____

Guardian Name: _____, Guardian ID: _____

Consent Agreement

I do hereby willingly consent to the following:

1. That I have been given information at the CSO about the MAT program
2. I have been taken through the rules and regulations of in the MAT program
3. I understand that participation in the program is voluntary
4. I have been informed of the risks and benefits of being in the MAT program
5. Although I understand that the treatment is beneficial to me, I have the right to withdraw from treatment
7. I agree to keep, and be on time for all my scheduled appointments with the service provider and his/her health care team at the clinic/treatment Centre.
8. I understand that the staff at the clinic/treatment Centre will need to confirm my identity every time before issuing my medication.
9. I agree to conduct myself in a courteous manner at the clinic/treatment Centre; No violence, verbal abuse, physical assault and repeated unacceptable destructive behavior to staff and or fellow clients.
10. I agree not to arrive at the clinic/treatment Centre intoxicated or under the influence of drugs. If I do, the doctor may not see me and I may not be given any medication until my next scheduled appointment.
11. I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without

recourse for appeal.

12. I agree not to deal, steal or conduct any other illegal or disruptive activities in the clinic/treatment Centre –Drug possession/dealing, carrying weapons and property damage within and around the facility.

13. I agree to collect my medication personally at my regular clinic/treatment Centre through daily visits and to consume the whole dose under direct observation of dispensing staff.

14. I understand that if I miss an appointment and fail to collect my medication on any day I will not be given an extra dose the following day.

15. I understand that if I miss three or more consecutive doses of my medication, the prescription will be cancelled and can only be renewed after another full medical check-up.

16. I agree that it is my responsibility to take the full dose of medication I receive from the clinic/treatment Centre staff. I agree that any medication that spills/drops while being taken will not be replaced regardless of the reasons for the loss.

17. I understand the dangers of taking more than my prescribed dose of methadone. I agree not to obtain similar medications from any other physicians, pharmacies or other sources without informing my primary treatment providers.

18. I understand that mixing my methadone/buprenorphine with other substances, especially alcohol, benzodiazepines such as Diazepam, and other drugs of abuse, can be dangerous. I also understand that death can occur among persons mixing methadone/buprenorphine with benzodiazepines.

19. I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.

20. I understand that methadone/buprenorphine alone is not sufficient treatment for my dependence and I agree to participate in the patient education and relapse prevention program, as provided, to assist me in my treatment.

21. I understand that the consent form will be administered after 3 months of induction and when need arise.

22. I understand that consenting to the above listed rules will apply to the mobile van. I will also be bound by all MAT clinic regulations.

I FREELY and VOLUNTARILY agree to undergo MAT at Karuri Health Centre or any other MAT outlet.

Client's Signature or Left thumb print: bbbbbb

Treatment Team

Designation	Name	Organization	Signature	Date
MAT Clinician	Peter Kiburi	Karuri Health Centre	nnnnnn	04/12/2025
MAT Counselor	Edith Mbugua	Karuri Health Centre	nnnnnn	04/12/2025