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|  | MEDICALLY ASSISTED THERAPY  CONSENT FORM | Form 3E  VER. SEPT. 2020 |

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Service Providers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MATID**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I ………………………………………………………..………… having freely and voluntarily agreed to be a client in the Medically assisted therapy (MAT) clinic for opioid dependence, do understand that the success of my treatment can only be achieved if I comply with the requirements.

I am freely and voluntarily willing and agree to undergo MAT at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Centre as follows:

1. 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.
2. I understand that the staff at the clinic/treatment Centre will need to confirm my identity every time before issuing my medication.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.
13. 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.
14. 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.
15. I understand that the consent form will be administered after 3 months of induction and when need arise.
16. 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.

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Client’ Signature/Thumb print Name Service provider’s Signature Date

***Reviewed after 3 months****;*

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Client’ Signature/Thumb print Name Service provider’s Signature Date