Transcultural Care
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Buprenorphine & Controlled Substance Treatment Agreement

I _____agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. I will keep my medication in a safe and secure place away from children (e.g., in a lock box). My plan is to store it (describe where and in what)? _____

2. I will take the medication exactly as my doctor prescribes. If I want to change my medication dose, I will speak with the doctor first. Taking more than my doctor prescribes or taking it more than once daily as my doctor prescribes is medication misuse and may result in supervised dosing at the clinic. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on the doctor's evaluation.

3. I will be on time to my appointments and be respectful to the office staff and other patients.

4. I will keep my doctor informed of all my medications (including herbs and vitamins) and medical problems.

5. I agree not to obtain or take prescription opioid medications prescribed by any other doctor.

6. If I am going to have a medical procedure that will cause pain, I will let my doctor know in advance so that my pain will be adequately treated.

7. If I miss an appointment or lose my medication, I understand that I will not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.

8. If I come to the office intoxicated, I understand that the doctor will not see me, and I will not receive more medication until the next office visit. I may also have to start having supervised buprenorphine dosing.

9. I understand that it is illegal to give away or sell my medication – this is diversion. If I do this, my treatment will no longer include unsupervised buprenorphine dosing and may require referral to a high level of care, supervised dosing at our clinic, and/or a change in medication based on the doctor's evaluation.

10. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from our clinic.

11. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.

12. I understand that I will be called at random times to bring my medication bottle into the office for a pill count. Missing medication doses could result in requirement for supervised dosing or referral to a higher level of care at this clinic or potentially at another treatment provider based on your individual needs.

13. I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit.

14. I can be seen every two weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row. I will then get a prescription for 14 days of medication at each visit.

15. I will go back to weekly visits if I have a positive drug test. I can go back to visits every two weeks when I have two negative drug tests in a row again.

16. I may be seen less than every two weeks based on goals made by me and my doctor.

17. I understand that people have died by mixing buprenorphine with other drugs like alcohol and benzodiazepines (drugs like Valium®, Klonopin® and Xanax®).

18. I understand that treatment of opioid addiction involves more than just taking my medication. I agree to comply with my doctor's recommendations for additional counseling and/or for help with other problems.

19. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.

20. I understand that I may experience opioid withdrawal symptoms when I go off buprenorphine.

21. I have been educated about the other two FDA-approved medications for opioid dependence treatment, methadone and naltrexone.

22. If female, I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and offered methods for preventing pregnancy.

23. If female, I have been educated about the effects of poor diet, illicit opioid use, use of dirty needles/sharing injection equipment, physical and mental trauma, and lack of pre-natal medical, substance use and mental health care during pregnancy and how these things can adversely affect my health and my current or future fetus/newborn's health. I understand that neonatal abstinence syndrome can occur when taking illicit opioids and that neonatal abstinence syndrome (NAS) is less severe, but can still occur, when pregnant women take methadone or buprenorphine as prescribed/dispensed in substance use disorder treatment. Cigarette smoking can make the severity of NAS worse and cause pre-term birth and small babies. Alcohol use can cause significant cognitive/brain damage in fetuses and newborns.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

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Authorization to Leave Personal Health Information by Alternative Means this includes information pertaining to Drug, Alcohol & Psychiatric Conditions

Patient Name: _____ DOB: _____

Patient Mailing Address: _____

Please fill all that apply:

May leave/share message on voicemail at home # (_____) _____

May leave/share message with spouse (name) _____

May leave/share info with other family (name) _____

May call or text detailed message on cell phone # (_____) _____

May leave/share detailed message at a different # (_____) _____

May send message to this email address _____

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Substance Use History

	No	Yes/Past/Now	Route	How Much	How Often	Quantity	Date/Time Last Use
Alcohol							
Caffeine							
Crystal Meth							
Ecstasy							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Sleeping pills							
Tranquilizers							
Other							

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FOLLOW UP VISIT FOR SUBOXONE

Name: _____ DOB: _____ Date: _____

SYMPTOMS (please circle one)

Stable: _____ Worse: _____ Improved: _____ Unchanged: _____

Have you had any cravings? (please circle)

NO: _____ YES: (explain) _____

_____

Since your last visit, have you relapsed? (if yes please specify which substance and when)

NO: _____ YES: (explain) _____

_____

Have you attended AA/NA meetings since your last visit? (if yes dates and location)

NO: _____ YES: (explain) _____

_____

Have you established a support network? (family, non-drug using friends, spouse, significant other)

NO: _____ YES: (explain) _____

_____