

Patient Name:

DOB:

CHB ID:

Agreement for Treatment with Suboxone

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. I agree to keep all of my ASAP appointments. If I must reschedule an appointment I will call the ASAP office as soon as I am aware of the need to change.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. I will report my history and symptoms honestly to ASAP staff. I will inform ASAP staff of all my other doctor and dentist appointments, and any medications (prescription or non-prescription) that I am taking. I will report any change in my medical history, such as becoming pregnant or developing hepatitis C.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. I will tell the ASAP staff if I have used alcohol or street drugs before a drug test result shows it.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. I agree to cooperate with urine drug testing whenever requested by ASAP staff, to detect whether I have used alcohol, prescription drugs, or street drugs.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. I understand that buprenorphine (as found in my medication, Suboxone) is a narcotic drug that can produce a 'high'. I know that taking buprenorphine regularly can lead to physical dependence and that if I abruptly stop taking it I could experience symptoms of opioid withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. I will take Suboxone by placing it under my tongue to dissolve and be absorbed. I will never inject Suboxone or take it IV because IV use could lead to sudden and severe opiate withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	7. I understand that Suboxone is a powerful drug. People who want to get high or sell Suboxone for a profit may want to steal my take-home prescription supplies. My medication must be protected from theft or unauthorized use. If my medications are stolen, I will file a report with the police and bring a copy to my next ASAP visit.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. I agree that my home supplies of Suboxone will be kept in the care of my parent or guardian.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	9. I understand that Suboxone must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else takes my Suboxone I will call 911 or Poison Control at 1-800-222-1222 immediately.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. I will be careful with my take-home prescription supplies of Suboxone. If I report that my supplies have been lost or stolen my doctors will not provide me with make-up supplies. I understand that if I run out of my medication before it is time for a refill I could end up experiencing symptoms of opiate withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. I will bring my bottle of Suboxone in with me for every appointment with my ASAP Clinician for a pill count. I understand that I will not get a refill prescription at my visit if I do not bring my pill bottle with me.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. I will take my Suboxone as prescribed. I will not skip doses or adjust the dose without talking with my ASAP doctor.

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<input type="checkbox"/> Yes	<input type="checkbox"/> No	13. I will not drive a motor vehicle or use power tools or other dangerous machinery while taking Suboxone until my ASAP doctor has cleared me to do so. I understand that I will be evaluated to resume driving after I have been on a stable dose of Suboxone for at least one month.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. My parent or guardian will accompany me to all of my Suboxone appointments until I am on a stable dose of medication and have been cleared by my ASAP doctor to drive or transport myself.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. I understand that it can be dangerous to mix Suboxone with alcohol or other sedatives (such as Valium, Ativan, Xanax, Klonopin)—so dangerous that it could result in accidental overdose, over-sedation, coma, or death . I agree to abstain from ALCOHOL and SEDATIVES while I am being treated with Suboxone. My ASAP doctor will discontinue my Suboxone treatment if I violate this agreement.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. I am not pregnant, and I will not have unprotected sex or attempt to become pregnant while taking Suboxone, because the safety of this medication during pregnancy is unknown. If I accidentally become pregnant I will inform the ASAP team as soon as I am aware so that they can refer me to a methadone clinic or for other appropriate treatment.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. I agree that medication management of addiction with Suboxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling as recommended by ASAP staff, while being treated with Suboxone.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. I agree to abstain from all drugs, including alcohol, marijuana and other street drugs. I understand that continued use of drugs can interfere with my attempts at recovering from opiod dependence. I also understand that buprenorphine (as found in Suboxone) is designed to treat opiod dependence, not addiction to other classes of drugs. Therefore, I will work with ASAP to design an individualized treatment program to assist me in discontinuing the use of other drugs.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are pursuing recovery, and as such I agree to participate in a regular program of peer/self-help, as recommended by the ASAP staff to suit my individual needs, while being treated with Suboxone.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment at ASAP.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. I agree that a network of support is an important part of my recovery, and honest communication among people within the network is important for my treatment. I will provide authorization to allow telephone, email, or face-to-face contact, between ASAP staff and physicians, therapists, probation officers, and parents to discuss my treatment and progress.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. I have been given a copy of the ASAP information sheet which includes hours of operation, clinic phone number and emergency contact information.

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Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

I agree with all of the statements on this page. By my signature above, I further agree that I will closely monitor my child for 24 hours before the first scheduled dose of Suboxone. If my child does not cooperate with monitoring I will inform ASAP staff prior to administering the first dose of medication.

ASAP Staff Signature/Title: _____ Date: _____