Appendix 4

Sample Methadone Maintenance Treatment Pharmacist–Patient Agreement

Patient's Name: _____

You can expect this pharmacy to provide you with professional service. Our goal is to provide you with the best pharmacy care possible in an environment that is safe and respectful for you, our other patients and pharmacy staff.

Please read, sign and date the Methadone Maintenance Treatment Pharmacist–Patient Agreement below.

- ☐ Methadone is a medication that is regulated by a number of legal and medical guidelines. I understand that I need a prescription to receive methadone. To receive a prescription, I have to keep my appointments with my doctor.
- ☐ I agree that I will receive prescriptions for methadone only from Dr. _____ (or his/her delegate).
- ☐ I will pick up my methadone during regular pharmacy hours. These are:
  Monday to Friday: 9:00 a.m. to 9:00 p.m.
  Saturday, Sunday and statutory holidays: 9:00 a.m. to 6:00 p.m.
- ☐ I understand that I need to present a valid photo ID (i.e., health card) each time before I can receive my methadone dose.
- ☐ It is best to take my methadone dose at the same time every day.
- ☐ I know that I will not be given my methadone if I am intoxicated with alcohol or other drugs because of concerns about my safety.
- ☐ I understand that the pharmacist will watch me take my dose and I agree to speak after taking my dose to confirm that I have swallowed the whole dose.
- ☐ I understand that my methadone will always be diluted in approximately 100 mL of juice.
- ☐ I will throw away my methadone cup/bottle in the pharmacy's designated garbage container.
- ☐ If I don't take methadone for three days, I will have to see my doctor for a new prescription. This may be sooner at the start of treatment.
- ☐ I understand that the pharmacy needs to be a safe place for patients and staff. I may no longer be able to get my medication here if I threaten anyone, act violently or partake in any illegal activity, which includes selling or distributing any kind of drugs at the pharmacy or in the surrounding vicinity.
- ☐ I agree to pay for my methadone dose. If I have a monthly drug card, I will submit the card at the beginning of each month.
- ☐ I understand that some medications are not safe or may interfere with methadone. I will tell the pharmacist if I am taking any other prescription or non-prescription (i.e., over-the-counter) drugs or herbal medicines.
- ☐ If any doctor or dentist plans to prescribe me any opioid medications, I will tell him or her that I am taking methadone. I know that it may be dangerous to my health and it is illegal not to do so.
- ☐ I agree to let the pharmacist discuss my treatment with my other health care providers, including doctors, nurses, therapists, pharmacists or anyone else who may be involved in my care.
- ☐ I understand that I have to pick up my take-home doses (carries) myself. No one else can pick up my carries. I also understand that I am responsible for the safe transport and storage of my carries.
- ☐ Before I can receive more take-home doses (carries), I agree to bring back to the pharmacy the container(s) in which my carries were given to me.
- ☐ I know that if I lose my carries, or if I vomit after taking a dose, my dose(s) can be replaced only if I get a new prescription from my doctor.

Patient's signature: _____ Date: _____

Pharmacist's signature: _____ Date: _____