

Contract for Patients Prescribed Opiate Pharmacotherapy

I (patient full name)..... Date of Birth...../...../.....

of (patient address).....

Medicare NumberConcession Card Number.....

agree to the following conditions during my treatment with Dr.....

I understand that breaking this contract may result in my treatment being terminated.

Medication details: drug name, dose & frequency (do not use the phrases
mdu/prn).....

Pharmacy to dispense (name, phone no.....

Frequency of collection from pharmacy (daily, weekly, etc).....

Conditions: This contract is valid from/...../..... until/...../.....

I agree to see **only** the above doctor/practice and pharmacy for my treatment.

I have informed my doctor of any past history of substance dependence or misuse. I understand that opioids can interact with other substances, especially sedatives. Therefore I will inform my doctor of any other medication or drugs I am taking - both legal and illegal.

I agree that my doctor may contact the **Medicare Australia** or **Poisons Control of the Department of Health and Families** to ask which drugs I have been prescribed by other doctors and who may advise other doctors, pharmacists and Alcohol & Other Drug Services Nurses of the drugs I have been prescribed.

I understand that opioids are drugs of dependence. The risks of dependence, tolerance and side effects such as cognitive impairment (confused thinking) due to the medication have been explained to me.

I understand that the provision of takeaway doses is by prior arrangement with my medical practitioner only. Under NT law, the maximum provision for takeaway doses is three per week for persons on daily methadone or buprenorphine (with or without naloxone), and a maximum of one takeaway dose per week for persons on alternate daily buprenorphine(with or without naloxone). Any takeaway doses in excess of this limit are only available after the issue of a special written authorisation by the Chief Health Officer.

I understand that no replacement or early scripts or medication will be provided to me. Looking after medications and scripts is my responsibility.

I agree to take the medication as prescribed and to attend my appointments regularly.

I understand that the opioid medication is only part of my treatment and agree to pursue other appropriate management measures as discussed with my doctor.

I understand that abusive, violent or threatening behaviour towards staff or other patients will not be tolerated and will result in termination of this contract. Drug use, diversion, selling or illegal activities on or near the doctor's surgery or pharmacy will result in termination of this contract.

I have read this agreement and understand it.

Signed (patient signature): Doctor/Witness: