



**North Canyon Family Medicine Clinic**

**Medication Assisted Treatment Program Consent Form**

***Thank you for considering North Canyon Family Medicine for your Medication Assisted Treatment. Opiate Addiction/Dependency is a serious condition for which you may find relief with Suboxone treatment. In order to increase your chance for successful treatment and due to the increased monitoring by the DEA, we have found the following guidelines necessary for us to follow. Please initial next to the following:***

1. \_\_\_\_\_ Buprenorphine is an FDA approved medication for the treatment of people with Opiate Dependence/Addiction. Qualified physicians may treat up to 200 patients at any given time for Opiate Dependence/Addiction. Buprenorphine can be used for detoxification or maintenance therapy with maintenance therapy lasting as long as medically necessary.
2. \_\_\_\_\_ Buprenorphine itself is an opiate and thus it can produce a “high”. Though not as strong as heroin or morphine, with regular use, Buprenorphine can lead to physical dependence and addiction, and abruptly discontinuing Buprenorphine can cause symptoms of opiate withdrawal.
3. \_\_\_\_\_ Combining Buprenorphine with benzodiazepine (sedative or tranquilizer) medications (including but not limited to Diazepam {Valium}, Clonazepam {Klonopin}, Lorazepam {Ativan}, Alprazolam {Xanax}, Chlordiazepoxide {Librium}, Oxazepam {Serax}) has been associated with severe adverse events including: ***ACCIDENTAL OVERDOSE, OVER SEDATION, COMA, or DEATH.*** Alcohol ***SHOULD NOT*** be used in conjunction with Buprenorphine as it could interact and produce decreased breathing or impaired thinking/behavior, the FDA advised no alcohol use while taking any form of buprenorphine. Attempts to override Buprenorphine with other opiates can result in ***ACCIDENTAL OVERDOSE, OVER SEDATION, COMA, or DEATH.*** You should not take any other medication without discussing it in advance with your Suboxone Treatment Provider. Violation of this term of treatment consent and contract may cause termination from the Suboxone Treatment Program.
4. \_\_\_\_\_ Suboxone contains the opiate narcotic analgesic Buprenorphine and the opiate antagonist drug Naloxone in a 4 to 1 ratio of Buprenorphine to Naloxone. The Naloxone is present in the tablet/film to prevent diversion to injected abuse of this medication. Injection of Suboxone by a person who is addicted to opiates will produce severe withdrawal.
5. \_\_\_\_\_ Suboxone tablets/films must be allowed to dissolve completely under the tongue. The Suboxone is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Suboxone will not be absorbed from the stomach if it is swallowed.
6. \_\_\_\_\_ The effect of Suboxone on an unborn fetus is unknown and could be harmful so it is required that birth control be used while in the Suboxone Treatment Program. If an accidental pregnancy is discovered, it must be reported to the treatment provider immediately so a referral to an alternative and appropriate treatment provider can be made.
7. \_\_\_\_\_ Suboxone itself will cost \$5.00 to \$12.00 a day just for the medication. If you have medical insurance, you should find out if it in fact will cover the cost of the Suboxone/ Buprenorphine. In all cases the office fees must be kept current. Office fees can be paid with cash, credit, or debit cards. ***The office will not accept personal checks for payment; no exceptions will be made for this requirement.***
8. \_\_\_\_\_ I have been informed of the alternative opiate dependence/addiction treatments available including medical withdrawal and drug free treatment, Naltrexone treatment, and Methadone treatment and I can be referred elsewhere if requested.



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I consent to obtain treatment for opiate dependence/addiction with Suboxone under the direct supervision of Dr. Reid W. Lofgran. By signing below, I certify that I have had an opportunity to ask the Provider all my questions concerning anticipated benefits, material risks, alternative therapies, risks of alternatives including refusal to have any treatment, and all of my questions have been answered to my satisfaction.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
(Please Print: First, Middle & Last Name)

\_\_\_\_\_  
**Patient Signature:** (or Authorized Representative)    **Relationship to Patient:**    **Time:**    **Date: (MM/DD/YY)**

**Witness:** As witness to this signature, I verify that the patient or authorized representative has read or had this form read to him/her, states the information is understood and has no further questions.

\_\_\_\_\_  
**NCMC Staff Member Name:** (Please Print)    **Time:**    **Date: (MM/DD/YY)**

\_\_\_\_\_  
**NCMC Staff Member Signature:**    **Title:**

Reid W. Lofgran, D.O.

\_\_\_\_\_  
**Physician Name:** (Please Print)    **Time:**    **Date: (MM/DD/YY)**

\_\_\_\_\_  
**Physician Signature:**