

## INFORMED CONSENT TO OPIOID (METHADONE) MAINTENANCE TREATMENT

I understand that I have been diagnosed as suffering from opioid dependence (*i.e.* that I am or have been addicted to an opiate drug, such as heroin or oxycodone) and that it has further been determined that an appropriate treatment is opioid maintenance therapy, which involves the daily use of medication (methadone), along with medical and rehabilitative (counseling) services, to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. The overall goal of opioid maintenance therapy is improved quality of life and freedom from illicit drugs.

I understand that methadone does not cure addiction, and is itself an opioid drug, which is addictive and can have serious, even fatal, side effects. The most commonly reported side effects are constipation and sweating/flushing. It may also cause dizziness, especially after sitting or lying down; drowsiness; mood changes; vision problems; difficulty falling or staying asleep; and sexual side effects. Serious and sometimes fatal side effects include seizures; severe allergic reaction; slowed or difficult breathing; and irregular heartbeat, especially in patients with certain existing heart conditions (known as prolonged QT interval).

I understand that mixing methadone with other depressants (such as alcohol or benzodiazepines) is especially dangerous and will refrain from doing so. I agree to take methadone only as prescribed, and to inform other healthcare providers that I take methadone to avoid potentially harmful interactions. Until I know how methadone will affect me, I will use caution when driving or operating machinery. I have made the Medical Director aware of all medical conditions I have and medications (prescription, over-the-counter, or illicit) I take, and will keep this information current throughout treatment.

I understand that methadone maintenance therapy generally takes place over an extended period of time, but that I am free to discontinue treatment at any time. I understand that if I stop taking methadone suddenly that it may produce severe withdrawal symptoms. I understand that at periodic intervals, and with my full consultation, the Program will discuss my present level of functioning, my course of treatment, and my future goals.

I understand that all medical decisions, including, but not limited to, diagnosis and treatment, are made by the Medical Director, who is a licensed physician independent contractor, or his designee (also a licensed independent contractor, if applicable), and hereby release the Program from any and all liability arising from such decisions.

While information contained in drug and alcohol abuse patient records is generally confidential under Federal law, reports of suspected child abuse or neglect are NOT protected and MUST be reported to the appropriate authorities.

I understand that other treatments are available, including, but not limited to, inpatient treatment, detoxification programs, buprenorphine treatment, and abstinence programs.

**FOR WOMEN WHO ARE OR MAY BECOME PREGNANT:** While methadone is approved by the FDA for medication-assisted treatment for opioid addiction in pregnant patients, there are no conclusive data regarding the safety of methadone in human pregnancy and it may be harmful to unborn babies. Tell your doctor and the Program's Medical Director if you are pregnant or plan to become pregnant. After delivery, babies may experience withdrawal symptoms. A small amount of methadone is transmitted through breast-milk; therefore, discuss breastfeeding with your doctor.

**Understanding the risks and benefits associated with methadone maintenance therapy, as well as alternatives to it, I hereby give my informed and voluntary consent to receive methadone maintenance therapy from We Care Arundel Health Services, Inc. and its Medical Director, a licensed independent contractor.**

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Witness' Signature

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Patient's Signature

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Witness' Printed Name

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Patient's Printed Name

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Date

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Date