

Suboxone Treatment Pharmacist-Client Agreement

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

Please read, sign and date the Suboxone Treatment Pharmacist-Client Agreement below.

Suboxone is a medication that is prescribed and dispensed according to a number of guidelines. I understand that I need a **prescription** to receive Suboxone and for that I have to keep my appointments with my doctor.

I will come for my Suboxone tablets during regular pharmacy hours.

I understand that I need to present to the pharmacist a **valid photo ID** each time before I can receive my Suboxone dose.

I know that I will not be given Suboxone if I am intoxicated with alcohol or other drugs because of concerns about my safety.

I agree to place the Suboxone tablet(s) under my tongue and let the dose dissolve. I understand this may take up to 10 minutes and that I have to **stay in the pharmacy** until the tablet(s) has dissolved completely.

I agree **not to swallow** the tablet(s). I agree to let the pharmacist check to make sure the tablet(s) has dissolved before I can leave the pharmacy.

If I don't take Suboxone for three days, I will have to see my doctor who may give me a **new prescription**.

I understand that the pharmacy needs to be a safe place for clients and staff. I may no longer be served here if I threaten anyone, act violently or take part in any illegal activity, which includes selling or distribution of any kind of drugs at CAMH or in the surrounding vicinity.

I agree to pay for my Suboxone tablets promptly.

I understand that some medications are not safe or may interfere with Suboxone. 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 drugs, I will tell him or her that I am taking Suboxone. I know that it is **illegal** and may be **dangerous** to my health not to do so.

I agree to let the pharmacist discuss my treatment with other health care providers, including doctors, nurses, therapists, pharmacists or; any one 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 in which my carries were given to me.

I know that if I lose my carries, my doses will be replaced only if I get a new prescription from my doctor.

Client's signature:

Date:

Pharmacist's signature:

Date: