

# Sample Methadone Maintenance Treatment Pharmacist-Client Agreement

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

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 have a prescription, I have to keep my appointments with my doctor.

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

I will pick up my methadone during regular pharmacy hours.

I will follow the pharmacist's directions when taking my methadone.

It is best to take my methadone dose at the same time every day. I understand that if I pick up my methadone late in the evening, I will have to wait at least 15 hours before I can get my next dose.

I understand that the pharmacist will watch me take my dose. I will speak with the pharmacist after taking my dose to show 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 in the pharmacy's designated garbage container.

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 pharmacy needs to be a safe place for customers and staff. I may no longer be served here if I ever threaten anyone or act violently while I am in the pharmacy. I also understand that I may no longer be served if I ever steal from the pharmacy, deal drugs here or stay here while I am not shopping or taking my methadone. I agree to pay for my methadone dose. If I have a monthly drug card, I will submit the card at the beginning of the month.

I understand that some drugs are not safe to take while I am on methadone. I will tell the pharmacist if I am taking any other prescription or non-prescription drugs or herbal medicines. I will bring in my prescriptions or medication bottles so the pharmacist knows exactly what I am taking.

I agree to let the pharmacist discuss my treatment with my doctor(s). If I have to go to the hospital or any other institution, I also agree to let the pharmacist give the hospital or institution information about my medicines.

If I don't take my methadone for three days, I will have to see my doctor for a new prescription.

I understand that I have to pick up my take-home doses (carries) myself. No one else can pick up my carries. I know that if I lose my carries, or if I vomit after taking a dose, my doses will not be replaced unless I get a new prescription from my doctor.

If any doctor or dentist plans to prescribe me any opioid drugs, I will tell him or her that I am taking methadone. I know that it is dangerous and illegal not to do so.

Client's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacist's signature: \_\_\_\_\_