Georgia Strait
WOMENS CLINIC

Agreement for Suboxone Treatment

By signing below, I agree to the following:

1. I understand that Suboxone treatment for opiate dependence is most effective when combined with appropriate counselling and other therapeutic services at Georgia Strait Women's Clinic ("GSWC").
2. I understand that in order to start Suboxone, I need to be in opiate withdrawal. The day before induction, I will not use any opiate (heroin, methadone, codeine or other opiate containing medications). If I am not having observable signs of opiate withdrawal, induction onto Suboxone may be delayed a day or more.
3. I understand that I will ingest a therapeutic dose of Suboxone as prescribed and required by GSWC's physician, Suboxone's Manufacturer, and Vancouver Coastal Health.
4. I agree not to take other controlled medications with Suboxone without prior permission from GSWC's physician. I understand that my risk of an overdose significantly increases when other medications or drugs have been taken (particularly medications like Librium, Valium or other benzodiazepines) with Suboxone.
5. I understand that Suboxone can produce physical dependence.
6. I agree I will not sell, share, or give any of my medication to another client. I understand that such mishandling of my medication is a serious violation of this agreement and may result in me being discharged from GSWC.
7. I agree that if I refused to start or discontinue Suboxone for any reason including adverse reaction, allergy, increase in symptom, that I will be discharged from the GSWC as part of licensing agreements.
8. I understand that it is the responsibility of myself or the funder of my treatment with GSWC to provide funding for the costs of my Suboxone prescription.
9. I understand that I will not be able to taper off Suboxone while at GSWC and that GSWC will arrange and transfer my Suboxone Prescription to an appropriate physician in my home community after treatment with whom I may discuss tapering.
10. I understand that if I return to opiate use, I need to use small doses of opiates until I learn what my body can tolerate in order to reduce the risk of overdose.
11. I understand that I may come back to GSWC for a complementary Suboxone taper after taking as prescribed for a minimum of 1 year and have achieved a stable recovery.

I have read and understand these details about Suboxone treatment. I agree to be treated with Suboxone at GSWC.

If you are signing on behalf of the attending client and they have not understood the expectations and requirements of Suboxone use at GSWC, you understand that they may be discharged if Suboxone is refused even after they've begun attending GSWC.

Client Signature: _____

Date: _____

Georgia Strait
WOMENS CLINIC

Refusal of Buprenorphine / Naloxone

Informed refusal of Buprenorphine/Naloxone Treatment

Date: _____

Client Name: _____

Dr. Jacques Dutoit has recommended that I undergo Buprenorphine/Naloxone Treatment:

I acknowledge the following (please initial):

_____ My medical condition has been explained to me by a health professional

_____ The reason for and/or purpose of Suboxone Treatment has been explained to me

_____ The nature of Suboxone Treatment has been explained to me

_____ The risks and benefits of Suboxone Treatment have been explained to me

_____ All of my questions about Suboxone Treatment have been answered

I understand that Georgia Strait Women's Clinic supports the recommendation outlined by the College of Physicians and Surgeons of British Columbia for buprenorphine/naloxone to be offered as the first line treatment option for persons living with opioid use disorders

I understand there is a high risk of relapse and/or overdose by choosing a withdrawal management protocol that it does not include the use of an opioid agonist alongside psychosocial interventions.

I choose to make the informed decision to refuse buprenorphine/naloxone Treatment and accept the risks and consequences of my decision. I understand that I can change this decision at any time by discussing with the doctor or Medical Services Manager at Georgia Strait Women's Clinic and taking action to cancel this refusal.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____