Appendix 2

Bradford and Airedale tPCT Supervised Methadone and Buprenorphine Scheme
Contract

Date.....…….....

Client Name .....

GP.....at .....…

Key Worker ..... Tel No .....

Pharmacy Address .....

Once this form has been completed you have been accepted onto the Supervised Methadone and Buprenorphine Scheme which operates in Bradford and Airedale. You will be able to receive a regular prescription, as part of a reduction programme, from the prescriber named above. Please be completely truthful about your drug use, to help the GP to prescribe the right dose of for you.

- Your prescription will be dispensed in daily/twice daily instalments at the chosen pharmacy. (delete as applicable)
- The pharmacist or member of staff will watch you consume your daily dose.
- Please note - the needle exchange scheme will remain as a confidential service. It is quite separate from the methadone and buprenorphine scheme.

Please read the rules shown below carefully.

If you do not keep to the rules your prescription may be stopped.

Please ask for more information if there is something that you do not understand.

Appointments, Prescription, and Medication

1. I agree to attend only the clinic / GPs mentioned on this form.
2. I accept responsibility for turning up for my appointments on time.
3. I agree to give urine specimens when required by the clinic or GP.
4. I understand that my prescription is a private matter between the GP, pharmacist, drug worker and myself. I will not discuss it with others.
5. I understand that the GP, the pharmacist and the drug worker are free to confer and exchange information about when I collect and when I fail to collect, and

about my behaviour, apparent state of health and other factors related to my treatment.

6. I also understand that all parties will continue to treat any usage of the needle exchange scheme as confidential and that information about this will not be exchanged.

7. I agree to be responsible for my prescription and medicines. I recognise that these cannot be replaced. I understand that no alterations can be made to the prescription except by my GP and then only on the original prescription form, prior to the amended supply.

8. It is my responsibility alone to ensure that I have a current prescription, and to visit the clinic / doctor when necessary.

9. I agree to collect my methadone/buprenorphine from the named pharmacy each day Doses will be supplied in advance to cover pharmacy closed days. I understand that Sunday's dose and any Bank Holiday doses will be dispensed on the last pharmacy opening day, if authorised on the prescription, and that I must look after any such doses and take them on the days for which they were supplied. If I lose any of these doses, they cannot be replaced.

10. I agree to attend the pharmacy at the arranged time daily.

11. I will attend unaccompanied, and will not loiter on or around the premises.

12. I understand that I will be required to consume my medication under the supervision of the pharmacist or member of staff in the pharmacy.

13. I understand that only exceptionally and by prior arrangement, will my daily dose be issued to any other person. No alteration can be made to the prescription by the pharmacist.

14. If I fail to collect my daily dose of methadone/buprenorphine I understand that the pharmacy will inform the prescriber. I also understand that the prescriber can cancel my prescription.

15. Any dose not collected and consumed will be subtracted from the prescription by the pharmacist; I cannot collect it later. I also understand that all doses up to the next due day (if not daily pick up) will also be forfeit unless the prescription states "If an instalment covers more than one day and it is not collected on the specified day, the total amount prescribed less the amount prescribed for the day(s) missed may be supplied."

16. I understand that, if I miss three consecutive days, the pharmacist will not dispense any further medication instalments before referring to the prescriber. I may have to return to the clinic for an assessment.

17. I agree not to take painkillers (except aspirin, paracetamol or ibuprofen) unless they have been prescribed by a health care professional.

18. I understand that methadone/buprenorphine are powerful drugs. They can cause serious harm or death in overdose. I understand that they are addictive. I understand that they can cause drowsiness. I know that I must not drive or operate machinery if I am affected by drowsiness. I know that they are more dangerous when taken with alcohol.

Behaviour

19. I understand that it is in my best interests to be truthful about my drug use. This means telling my doctor the amount of any drug I have been taking, including alcohol.

20. I will not come to the pharmacy under the influence of alcohol or other drugs, and I understand that smoking and the consumption of alcohol on these premises is forbidden.

21. I agree not to upset the staff or patients in the pharmacy.

Agreement
Client

I have read the terms of this contract, been given a copy, and I understand what they mean. I agree to abide by them and I understand that if I do not, my doctor will be informed and drug treatment services may be withdrawn.

Signature ..... Date .....

Pharmacist

I agree to supervise the self administration of methadone or buprenorphine by this client in this pharmacy, in accordance with prescriptions issued by the prescriber named in this contract. I have provided information on suitable times to collect the daily doses.

Signature ..... Date .....