

METHADONE MAINTENANCE TREATMENT EXPECTATION FORM

As your pharmacists, we believe in the principles of the methadone maintenance treatment program, and the valuable role it can play in improving people's lives and their health. We are committed to being an active member of your healthcare team and understand that the success of the program is dependent on ongoing collaboration and communication between yourself, ourselves and your prescriber.

To help you succeed in the program it is important that we both clearly understand the commitment and expectations of each other.

As your pharmacists, you can expect that we will:

- Treat you professionally and respectfully at all times.
- Make ourselves available to discuss any questions or concerns that you may have regarding the program.
- Provide methadone to you exactly as your physician has prescribed it and will ensure that they are made aware of any of the following:
 - Missed dose(s) for any reason (ie; failure to pick up, vomited, lost or stolen)
 - Less than full dose consumed (ie; tolerance, self-initiated tapering)
 - Presenting at the pharmacy while intoxicated
 - Prescribing of contraindicated medications (ie; mood-altering drugs)
- Not dispense your methadone (unless directed by your prescriber) to anyone other than you.
- Respect your choice (unless directed by your prescriber) of the pharmacy you wish to have dispense your medication.

As our patient, we can expect that you will:

- Treat all pharmacy staff and other patients respectfully at all times.
- Do your utmost to adhere to the methadone maintenance treatment program as prescribed to you.
- Discuss any concerns you may have regarding your methadone maintenance treatment with us or your prescriber prior to making any adjustments to treatment independently.
- Ensure that any take-home doses of methadone are stored safely and securely.
- Respect the pharmacies greater community by refraining from loitering or littering.

Patient's Name: _____

Patient's Signature: _____

Pharmacist's Name: _____

Pharmacist's Signature: _____

Date: _____