2021 Methadone/Suboxone Maintenance Forms For Inpatient Program

Cree Nations Treatment Haven

Box 340

Canwood, SK

S0J 0K0

Phone: 1-306-468-2072

Fax: 1-306-468-2758

Fax completed application

Phone if you have any questions or concerns

I. Methadone/Suboxone Maintenance Program

To refer an applicant on methadone to the Methadone Maintenance Program at CNTH, you must contact the Intake Coordinator to ensure your applicant meets the following requirements.

1. The applicant requirements include:

- A history of having been **stabilized** on methadone for **4 weeks with a daily therapeutic dose. This means the dosage of methadone/suboxone has not been in the process of upward titration in the last 4 weeks. Stabilization** would be when a person is **not** experiencing withdrawal symptoms or cravings (occurs when under medicated) or drowsiness (nodding) or constriction of pupils (occurs when over medicated).

- **Be abstinent free for 3 DAYS** from alcohol, illicit drugs, medical marijuana and medications listed on our unsafe list.

2. The applicant must be approved, by their prescribing physician, to receive prescription carries for their methadone/suboxone. This is for the purpose of the applicant to have a "carry" dose **(in a mandatory lock box)** to arrive at CNTH and return to their home community, as it will be dependent on the amount of travel time to and from CNTH.

3. Please note the applicant's first dose of methadone/suboxone will be dispensed starting on the Thursday of the intake week. It is important to note the applicant will be responsible for their Wednesday dose of the intake week, which could be in the form of a carry dose.

4. Only after receiving confirmation of the applicant's admission to CNTH, it is **mandatory** that the applicant's prescribing physician **faxes the original prescription to Prince Albert Medi-Centre Pharmacy (306-764-0602) and Cree Nations Treatment Haven (306-468-2758) by the Tuesday prior to the intake date.**

5. Prior to admission, the applicant will sign the Methadone/Suboxone Maintenance Program Contract with the prescribing physician.

6. It is imperative that the applicant be aware of the mandatory supervised urine samples that may be requested for drug screening upon admission or if deemed necessary.

7. The applicant understands that methadone/suboxone is a witnessed dose, under supported self-administration, by the resident nurse or other qualified personnel in the nurse's office. Applicant's methadone/suboxone dosage will not be altered while in treatment.

J. Methadone/Suboxone Maintenance Program Contract

(To be completed with methadone prescribing physician and applicant)

This contract shall be between _____ (applicant) and Cree Nations Treatment Haven

My start date on methadone/suboxone was _____

My current dose of methadone/suboxone is _____

I started taking my current dose of methadone/suboxone on _____

I have been on my current dose of methadone/suboxone for _____

I understand that Cree Nation Treatment Haven requires me to be stabilized on this current dose of methadone/suboxone for at least four weeks. **This means the dosage of methadone/suboxone has not been in the process of upward titration in the last four weeks.**

My prescribing physician is Dr. _____ of _____

Phone Number _____ Fax # _____

Please initial all boxes as acknowledgement of the contract guidelines

- ☐ I acknowledge that I come to CNTH **stabilized** on a methadone/suboxone program.
- ☐ I acknowledge that I have **three days abstinence** from alcohol, illicit drugs, medical marijuana, and medications from the unsafe list.
- ☐ I acknowledge that I have an opioid use disorder and wish to continue my methadone/suboxone program while at the Cree Nation Treatment Haven.
- ☐ I agree that while at CNTH, I will daily receive my methadone/suboxone dose from the resident nurse or a qualified designate.
- ☐ I agree to adhere to the program guidelines as detailed to me upon orientation to the facility.
- ☐ I understand that my failure to participate in the program as outlined will result in a review of my suitability stabilization for the treatment program.
- ☐ I **agree to a supervised urine sample for drug screening as requested**. I understand that failure to comply will result in termination from the program.
- ☐ I will swallow my methadone, witnessed, as according to the protocols.

Physician to witness the proceeding,

_____ _____

PHYSICIAN SIGNATURE DATE

_____ _____

APPLICANT SIGNATURE DATE