Agreement to Participate in the Medication-Assisted Treatment (MAT) Program

The Red Lake Hospital offers a medication-assisted treatment (MAT) service to patients with opioid use disorders who meet American Society of Addiction Medication (ASAM) Criteria for outpatient treatment with Naltrexone (Vivitrol). We are committed to implementing the program in a way that's consistent with our mission, values, and vision as well as with your long-term recovery. Taking part in medication-assisted treatment means you will stay engaged with services for an extended period of time and comply with measures of accountability. More specifically, you agree to do the following:

- participate in the continuum of care as clinically recommended
- follow the advice and recommendations of our medical staff
- take all medications as prescribed and approved by our medical staff
- comply with ongoing drug testing, monitoring, or both
- participate in scheduled programming and comply with treatment expectations
- attend all scheduled appointments
- participate in ongoing opioid-specific support groups
- maintain ongoing willingness to include family and other third-party supports in the treatment program
- actively participate in Twelve Step meetings and the recovery community

You also need to understand that any of the following can result in being asked to leave the program:

- noncompliance with the above conditions of participation
- misuse, abuse, or diversion of medications
- using, possessing, or supplying mood-altering substances
- inappropriate sexual behavior, innuendo, or harassment of any kind
- leaving the treatment site without staff permission
- unlawful activity of any kind, including, but not limited to, violence or theft, whether in connection with our staff and/or property or otherwise

I want to participate in the Red Lake MAT program and agree to follow the above guidelines.

Patient:

PRINT NAME

_____

SIGNATURE / date

_____

Parent or guardian *(if under the age of eighteen)*:

PRINT NAME

_____

SIGNATURE / date

_____

Pharmacist:

PRINT NAME

_____

SIGNATURE / date

_____

Physician:

PRINT NAME

_____

SIGNATURE / date

_____