

Agreement for Abstinence

<input type="radio"/> YES	<input type="radio"/> NO	I understand that other methods are available to treat opioid addiction including medications and I have chosen abstinence as my best option.
<input type="radio"/> YES	<input type="radio"/> NO	I agree to abstain from drugs and alcohol during my incarceration.
<input type="radio"/> YES	<input type="radio"/> NO	I understand that I will be seen periodically to allow me to reconsider other options to treat opioid addiction. Treatment options will also be discussed with me 4 months prior to my anticipated release date.
<input type="radio"/> YES	<input type="radio"/> NO	I agree to let medical or mental health staff know if I experience cravings that interfere with my activities of daily living.
<input type="radio"/> YES	<input type="radio"/> NO	I understand that I can use the sick call process to access medical services to include other options to treat opioid addiction.
<input type="radio"/> YES	<input type="radio"/> NO	I understand that my release date may impact my ability to begin medication assisted treatment while in custody.
<input type="radio"/> YES	<input type="radio"/> NO	I understand that substance abuse counseling/mental health visits are available should I want to make use of these services.
<input type="radio"/> YES	<input type="radio"/> NO	I have been given information on resources regarding treatment of opioid addiction available to me while in custody and in the community.
<input type="radio"/> YES	<input type="radio"/> NO	I have had the opportunity to ask questions and to have those questions answered to my satisfaction.

Patient signature

Date

Witness signature

Date

Patient Name	ID#	DOB	Date / Time