wellpath To hope and healing.	**Wellpath Informed Consent for Buprenorphine (+/- naltrexone)**	Patient Name (Last, First, MI):		
Date of Birth:	☐	Patient ID No:	DOC Commitment Number:	Date:

Buprenorphine: Belbuca®

Buprenorphine/Naltrexone: Suboxone®

FOR INFORMATIONAL PURPOSES ONLY. FOR SPECIFIC INFORMATION CONSULT YOUR PHYSICIAN

About Buprenorphine: This medication is used to treat Opioid Use Disorder including withdrawal and Medication Assisted Treatment for addiction. Buprenorphine is a partial agonist (i.e. activates the opioid receptors, but to a lesser degree than a full agonist like heroin or oxycodone, while also acting as an antagonist blocking other opioids.)

How to Use: This medication is held between the cheek and gum or underneath the tongue depending on the formulation. You will be shown the technique for this by health care staff. This medication should not be used in patients less than 16 years of age.

Risks and Hazards: Buprenorphine +/- naltrexone should not be given to patients who have had significant reactions to any of these medication in the past.

Side Effects: These medications can cause side effects. The most common side effects are headache, sweating, nausea, constipation and abdominal pain. Report to health care staff if any of these symptoms are disruptive to activities of daily living or persist. Some side effects can be serious. The following symptoms are uncommon, but if you experience any of them, report them to medical staff immediately: chest tightness, shortness of breath, severe skin rash, swelling of the lips, seizures, weakness, or numbness. Alert your medical provider if you have any unusual problems after receiving this medication.

Notifications:
By signing this form, I, the patient, or as guardian of the above-named patient consent to receiving the buprenorphine or buprenorphine/naltrexone. I have been informed of the risks and hazards associated with this treatment, and the possible side effects that I may experience from this treatment.
I have been given a chance to ask questions about my treatment and all my questions have been answered. I understand that I can discuss any other questions I might have about my treatment with the medical staff and that a copy of this form may be reviewed upon my request. I have read, or have had read to me, this form and I understand all of its contents. I sign this willingly in full understanding of the above and release Wellpath, its employees and agents, the State, statutory authority and all correctional staff from any and all liability, which may arise from this action.

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I do NOT wish to receive buprenorphine at this time. I have been fully informed of the risks and benefits of this decision and understand them completely. Furthermore, I understand that should I change my mind, I should use the sick call process to bring this decision to the attention of medical personnel.

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Verbal Consent obtained. Reason: _____

Patient/ Guardian Name (Printed):		Patient/ Guardian Signature:	Date:
Witness Name (Printed):	Date:	Witness Signature:	Date:

Patient has provided verbal consent			
Provider Signature:	Title:	Date:	Time:
Witness Signature:	Title:	Date:	Time: