# Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

Name of Patient_____ Date_____

Date of Birth (MM/DD/YY)_____ Patient's Age_____ Pregnant: Yes___ No___

Name of Parent or Legal Guardian_____

Name of Practitioner Explaining Procedures_____

Name of Program Medical Director_____

An individual under 18 years of age, who is not pregnant, is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment.

No individual 16 or 17 years-of-age may be admitted to maintenance treatment unless a parent or legal guardian consents, in writing, to such treatment. For persons 15 years-of-age and under, a parent or legal guardian consent is required, as well as permission for admission by the state opioid treatment authority (SOTA). A copy of the program's signed informed consent statement must be placed in the individual's clinical chart. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and shall be filed in their clinical charts.

The parent or legal guardian must sign a release of information for the Opioid Treatment Program (OTP) staff to verify the individual's admission and discharge dates and any other specific information requested by the OTP.

**Verification of Detoxification/Drug-Free Treatment Attempts**
**(DOES NOT APPLY TO PREGNANT ADOLESCENTS)**

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number _____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

***Verified by:***

*OTP Staff Person Name*_____

*Title*_____

*OTP Staff Signature*_____

*Date*_____

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number_____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

***Verified by:***

*OTP Staff Person Name*_____

*Title*_____

*OTP Staff Signature*_____

*Date*_____

**INFORMED CONSENT STATEMENT**

**FOR PARENT/GUARDIAN**

I hereby authorize and give voluntary consent to _____ Medication-Assisted Treatment Program and its medical personnel to dispense and administer opioid pharmacotherapy (includes methadone or buprenorphine) as part of the treatment of my child's addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve taking the prescribed opioid drug on the schedule determined by the program physician in accordance with federal and state regulations.

I further authorize provision of the following: diagnostic assessment, individual and group counseling, medication review and monitoring. My child's participation is voluntary. I understand that this program follows person-centered planning guidelines and that my child's treatment plan will be individualized to meet my child's needs and goals, and I will participate in the development of my child's treatment plan.

I understand that it is important for me to inform any medical provider, who may treat my child for any medical problem, that my child is enrolled in an opioid treatment program so that the provider is aware of all the medications my child is taking, can provide the best possible care, and can avoid prescribing medications that might affect the opioid pharmacotherapy or the chances of successful recovery from opioid addiction. If pregnant, my child will receive prenatal care and I will sign releases for coordination of care with that provider.

I understand that I may withdraw my child, from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand my child will be offered a medically supervised tapering process for discontinuation. Withdrawal is not recommended when the individual is pregnant.

**Parent/Guardian:**

Name _____ Signature_____ Date_____

**Witness:**

Name _____ Signature_____ Date_____

**OTP Physician:**

Name _____ Signature_____ Date_____

**State Opioid Treatment Authority** (Required for minors 15 years-of-age and younger.)**:**

Name _____ Signature_____ Date_____