Consent for Suboxone (Buprenorphine/Naloxone) Treatment

Informed Consent for Medication-Assisted Treatment of Opioid Use Disorder

Dr. Nezih Z. Hasanoglu · Suboxone Maintenance Program · 10150 W. National Ave., Suite 202, West Allis, WI 53227 · 414-213-1505

1. Patient Information

Patient printed name: _____ Date of birth: _____

2. Purpose of Treatment

I am being treated for opioid use disorder with Suboxone (buprenorphine/naloxone), a medication used to reduce withdrawal symptoms and cravings, under the care of Dr. Nezih Hasanoglu. This is a maintenance program, not counseling or psychotherapy; medical care is provided by Dr. Hasanoglu, with intake, screening, and monthly check-ins coordinated by Deb Hasanoglu.

3. How Suboxone Works

Suboxone combines buprenorphine (a partial opioid agonist that reduces cravings and withdrawal without producing the intense effects of full opioids) with naloxone (included to discourage misuse). It is considered a standard medical treatment for opioid use disorder and is intended to be used alongside honest communication with my care team, not as a replacement for it.

4. Risks I Have Been Informed Of

- Starting Suboxone too early, before withdrawal has sufficiently begun, can cause precipitated withdrawal — a sudden, severe reaction. My care team will guide the timing of my first dose to help avoid this.
- Combining Suboxone with benzodiazepines, alcohol, or other sedatives can cause dangerous, potentially fatal respiratory depression. I have disclosed my full medication and substance use history to my care team.
- Like any medication, Suboxone can cause side effects (e.g., constipation, headache, nausea, sweating).
- Suboxone itself carries a risk of physical dependence; stopping it abruptly can cause withdrawal symptoms. Any changes to my dose or plans to stop should be discussed with Dr. Hasanoglu first.
- Sharing, selling, or diverting my medication to anyone else is dangerous, illegal, and grounds for discharge from this program.

5. Benefits

Suboxone maintenance treatment is associated with reduced opioid cravings and withdrawal, reduced risk of overdose compared to untreated opioid use disorder, and improved ability to function in daily life while the underlying condition is treated.

6. Alternatives to This Treatment

Alternatives that were discussed with me include: methadone maintenance treatment (through a licensed opioid treatment program), other medications for opioid use disorder, medically supervised withdrawal without ongoing medication, counseling or peer-support-based approaches without medication, or declining treatment altogether. I understand each alternative has different risks and benefits, and I have chosen Suboxone maintenance treatment with this practice.

7. What This Program Requires of Me

- Regular monthly visits and saliva screens, as scheduled, either in person or virtually.
- Honesty with my care team about my substance use, medications, and how I'm doing.
- Not using benzodiazepines while in this program (I have been screened for this).
- Storing my medication safely and never sharing it with anyone else.
- For virtual patients, completing one in-person visit within six months of starting treatment, as required by Wisconsin law.

8. Confidentiality

My treatment records are protected under federal law (42 CFR Part 2), which provides stronger confidentiality protection than standard medical records. Information about my treatment will not be shared without my separate written consent, except as permitted by law (e.g., a medical emergency).

9. My Right to Stop Treatment

My participation in this program is voluntary. I may choose to stop treatment at any time, though I understand stopping Suboxone abruptly can cause withdrawal, and I am encouraged to discuss any decision to stop with Dr. Hasanoglu first so it can be done as safely as possible.

10. Acknowledgment

I have read (or had read to me) this consent form. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I voluntarily consent to Suboxone maintenance treatment with Dr. Nezih Hasanoglu under the terms described above.

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

If signed by a personal representative rather than the patient, print name, relationship, and attach proof of authority (e.g., healthcare power of attorney, guardianship).

Representative printed name / relationship: _____