MMT PATIENT TRANSFER FORM

To be completed by the *referring* physician (or designate) once the receiving physician has been contacted and a mutual agreement has been reached to transfer the named patient.

Ensure a release of information form has been signed by the patient.

Surname: _____ Given Name(s): _____

Date of Birth: _____ Personal Health Number:_____

Transfer from: _____
(Name of physician and clinic or organization)

Phone: _____ Fax: _____

Transfer to: _____
(Name of physician and clinic or organization)

Phone: _____ Fax: _____

Reason for transfer:_____
(restabilization, maintenance, relocating, etc.)

Appointment date and time with receiving physician: _____

Current prescribed methadone dosage:_____

Expected date of first dose with receiving physician: _____

Last dose prescribed by referring physician: _____ mg Date: _____

Name of current dispensing pharmacy: _____

Phone: _____ Fax: _____

Patient aware of daily dispensing fee: Yes ☐ No ☐

Method of payment for dispensing fee: _____

Alberta Human Resources and Employment (AHRE) Information if applicable: _____

_____

Carries: Yes ☐ No ☐

Carries schedule:

Doses circled are to be witnessed ingestion(s): ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Doses circled are to be dispensed as carries: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Other: _____

_____

Number and dates of carries currently in patient's possession:

_____ _____

_____ _____

Other medications: (List and include dose)

_____

_____

_____

Health concerns: _____

_____

_____

Patient Transferring Interprovincially

Name of courtesy (temporary) pharmacy in Alberta: _____

Phone: _____ Fax: _____

File Information to be Provided

- ☐ Addiction assessment
- ☐ History and Physical Examination
- ☐ Last 3 months UTT results
- ☐ Admission bloodwork, ECG, CXR etc.
- ☐ Follow-up laboratory results
- ☐ Copy of last Rx

Signature of Referring Physician/Designate Date

_____ _____