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** _____

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)

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

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

Other

Number & 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.
- ☐ Work-up laboratory results
- ☐ Copy of last Rx

Signature of referring physician/designate Date

Print Form

_____ _____