C E N T R E J U B I L E E C E N T R E

Substance Abuse Treatment Centre – Centre de traitement pour toxicomanes

OPIOID REPLACEMENT THERAPY MEDICAL FORM (Appendix A")

Confidential

CLIENT'S PERSONAL INFORMATION

FULL NAME : _____

HEALTH CARD NO.: _____ VERSION CODE: _____

D.O.B (dd/mm/yyyy):_____ TEL. NO.: _____

FULL ADDRESS : _____ POSTAL CODE: _____

PHYSICIAN INFORMATION

PHYSICIAN NAME : _____ CPSO NO.: _____

NAME OF CLINIC: _____

CLINIC ADDRESS: _____ POSTAL CODE: _____

TELEPHONE NO.: _____ FAX NO.: _____

METHADONE/SUBOXONE/SUBLOCADE INFORMATION *To be completed by the prescribing physician:*

What Opioid Replacement Therapy is your client currently receiving?

□ Methadone
□ Suboxone
□ Sublocade

When did your client first start Opioid Replacement Therapy? _____

What is the client's current dose and frequency? _____

How long has the client been on this current dose? _____

Does your client experience any negative side effect due to Methadone/Suboxone/Sublocade Treatment that could affect their participation at our residential treatment centre? □ YES □ NO

If yes, please describe:

Additional details

If your client is recommended for and accepts additional time in treatment, may we contact you in order to make arrangements for the client's prescription? □ YES □ NO

May we contact you for further information regarding your client ? □ YES □ NO

****Please note prior to admission a letter will be sent to you in order to confirm details****

_____ _____

Prescribing Physician Signature Date (dd/mm/yyyy)