Request Transfer from Methadone Maintenance to Office-Based Opioid Treatment Utilizing Buprenorphine

Client Name: _____

Date: _____

Admission Date: _____

ID#: _____

DOB: _____

Transfer Criteria (please check the appropriate box and fill in as much information as possible):

☐ On 30mg or less of Methadone.

☐ Negative drug toxicology screens.

If there are positive drug screens, how many over the last 12 months: _____

☐ No missed methadone doses in the last 3 months.

If there are any missed doses, how many over the last 12 months: _____

☐ Receiving primary care.

☐ Able to appropriately conduct self in an office-based medical setting:

- No prior history of episodes of inappropriate behavior in the clinic or any other medical setting.
- Handles frustration, long waits, avoids conflict.
- Appropriately engaging with staff and others.

☐ If woman of childbearing age, must be on some form of birth control with no immediate desires to become pregnant and understands if pregnancy occurs, she may need to be transferred back to Methadone Maintenance.

<u>Counselor Section:</u>

Clinic site: _____ Number: _____

Counselor: _____ Number: _____

Length of time on Methadone: _____ Maximum dose: _____ Current dose: _____

Length of time on current dose: _____

Does the client receive take-homes? Y/N

If yes, how many take-homes does the client receive? _____

Name of primary care physician: _____

Number: _____ Last appointment: _____

Social History:

Client's living situation - alone or with others? _____

If with others, who? _____

Does anyone in client's home currently use or have a history of addiction to drug or alcohol Y/N

(explain): _____

_____

Is anyone in client's home on Methadone or Buprenorphine? Y/N

If yes, who? _____

Is the client currently seeing a psychiatrist Y/N

If yes, name/number: _____

If in care of psychiatrist, release is signed and attached: Y/N

What medications? _____

Has the client ever tried to harm him/herself or others? Y/N

If yes, how/when: _____

Has the client ever been hospitalized for mental health issues? Y/N

If so, when, and for what? _____

_____

_____

Counselor Signature: _____ Date: _____

**Please include letter stating that client has been compliant with counseling and psychiatric follow up (if warranted based of diagnosis)

Clinic MD Name: _____ Date: _____

Medical and psychiatric problem list: _____

_____

_____

Medications: _____

_____

Allergies:_____

_____

Do you think this patient is a good candidate for office-based opioid treatment with Buprenorphine? Y/N

Comments: _____

_____

_____

Date: _____

Reviewed: Y/N

Approved: Y/N

Comments: _____

_____

_____

Administrative review: Y/N Date: _____

Adapted from materials produced by Colleen LaBelle, RN at Boston Medical Center