

# MMT PATIENT TRANSFER FORM

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**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

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