

**Internal Use Only**

Community:  
 ASIST ID:  
 Meditech ID:

**Medical Suitability Form**

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PATIENT INFORMATION	
<b>Legal Name:</b> (Last, First, Middle)	
<b>PHN:</b>	<b>Date of Birth:</b> (dd/Mon/yyyy)
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> _____	
<b>Client Contact Info:</b> (required as we cannot reach patient without phone number or alternate plan) <input type="checkbox"/> Phone Number: _____ <b>OR</b> <input type="checkbox"/> Alternate Plan (e.g., client will be at X shelter): _____	

REFERRAL SOURCE INFORMATION	
<b>Name:</b>	
<b>Practice ID #:</b> N/A	
<b>Check one:</b> <input type="checkbox"/> Family Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Other:	
<b>Tel:</b>	<b>Fax:</b>

SUITABILITY FOR OPIOID DEPENDENCY TREATMENT		
	Check	Details
Opiate Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medically Stable	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Significant Respiratory Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Benzodiazepine Use (Benzo. use can be dangerous with ODP tx)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Relevant Information	Date Released:  Medication:  Dose:  Last taken:	

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Medication	Dose/Frequency

**Previous ODT Treatments** (Including When, Where and Why Stopped)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/Mon/yyyy)

**Please fax completed form to 403-783-7610**

**If you have any questions or concerns do not hesitate to contact  
the Virtual Opioid Dependency Program at 403-783-7688 or Toll  
Free at 1-844-383-7688**