

Internal Use Only
Community:

Medical Suitability Form

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

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

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	
Alcohol Use (Alcohol use can be dangerous with ODP tx)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Relevant Information	Date Released: Medication: Dose: Last Taken:	

<p>Internal Use Only Community: ASIST ID: Meditech ID:</p>
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Medical Suitability Form

Medication	Dose/Frequency

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

Signature _____

Date (dd/Mon/yyyy) _____

Please fax completed form to 403-355-0666

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