**SUBOXONE CLINIC MEDICAL INFORMATION REQUEST**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This portion is to be completed by either your counselor, current Suboxone provider, or program leader:**

**Counselor or program leader fill out and fax to the attention of Suboxone Intake Coordinator. Once completed and sent back we can move forward with patient care.**

1. Does this patient attend regular appointments?
2. Have there been any positive urine screens for non Rx’D substances? YES NO
3. Is this patient involved in other programs and if so which ones?
4. Will this patient be graduating from your program? When?
5. Current prescribed Suboxone dosage? Our max dosage is 16 mg of buprenorphine daily. If patients are on higher doses we will work with them to taper down over a few months if they are willing.
6. We offer 1-2 clinical sessions a week for patients on Suboxone. At this time, we do not have on site addiction counseling so we are unable to best serve patients requiring more intensive recovery support. Do you think this patient will be a good fit?
7. Comments/Concerns

**Name of counselor completing form (PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**