Rising Sun Treatment Center

DOCTOR VERIFICATION FORM

Opioid Replacement Program Pilot

ORT

Revised for Sept. 26/2016

Name of Client's Methadone/Suboxone Doctor ____

Your Client ____ Health Card # ________________________

DOB: DD/MM/YY

Has expressed interest in participating in our inpatient ORT (Opioid Replacement Treatment) Program, offered here at the Rising Sun Treatment Centre.

In order for us to process the application further , we need to establish the dispensing of the proper dosage and medication through our participating Pharmacy (medicine Shoppe in Miramichi)

The doctors that will be assisting us with the clientele during the period of _______________________are as follows:

Dr. John McCann	Dr. Jeff Hans	Dr. Linda Hudson

The prescriptions will have to follow a system in order for client, staff, pharmacy and all Doctors to work together. Ultimately the goal is to help this individual develop confidence; use some tools to cope with either coming completely off the Opioid Replacement or to reduce the dose safely.

1. Prior to arrival we need from you (the Clients Doctor) to verify that this client has been stabilized on a regulated dose no higher than 100 mg Methadone for a minimum of 4 months prior to their application to this program.
2. The client will remain on this amount during the entire program that is why they have to be stable. They will not go up in dose or go down unless emergency presents itself.
3. A prescription will have to be made to our pharmacy (Medicine Shoppe) for the date of arrival until they are seen by one of our corresponding Doctors. This will happen no later than Wednesday the first week. At which time one of these three doctors will meet the client in person and oversee or take over the regulating of the prescription while the client is staying with us here at the Rising Sun. Methadone will not be stored on site we are utilizing the local pharmacy.

Upon discharge, this client will need a follow up and an appointment with your office as to when the Prescription can be returned to your office (Transferred back to the original Doctor)

Our Doctors will need the Pharmacy name, phone #, and Fax # to make sure the client's prescription is returned to their home pharmacy until which time you are able schedule an appointment for this client post-treatment and resume your file.

Each client will be made aware of the protocol that there will be no weekend passes during this program and should they be dismissed or leave before the dates set aside for maintenance that they will be in jeopardy of missing doses. Especially if they don't return to your office with the first few days without a plan.

Should this occur, your office will be notified by our office via fax or email. And also by the pharmacy. To the effect of this client has left program on a certain date.

Fax the patient's recent treatment sheets/ notes
This will notify the attending Doctor
(to allow continuum of care)
to the PHARMACIST on Duty
at Medicine Shoppe, 106 New Castle Blvd
Miramichi NB E1V 2L7
Phone(506-622-7000)
Fax Number : 506-622-8323

Home Pharmacy ______________________________

Home Pharmacy Phone # ______________________________

Home Pharmacy Fax # ______________________________

Initial the statements below

________ That you are this client's primary physician regarding Methadone/Suboxone, verify that this client meets the requirements for attending program.

________ Dose is no higher than 100 mg Current dose on file for this client is __________ mg

________ This client has been stable on this dose for a minimum of 4 months or more.

Planned discharged date from the Rising Sun will be ____________________________.

What the next possible date (appointment) is for this client at your office, once he/she is finished with our program?

DD	MM	YY

Date signed: DD/MM/YY _________________________

PHYSICIAN'S SIGNATURE OR OFFICE STAMP