

BUPRENORPHINE PATIENT TRANSFER SUMMARY
To Primary Care Providers for Buprenorphine Therapy

Patient Information

Patient Name: _____ Patient DOB: ____/____/____

Patient Address: _____

Patient Phone: () _____ - _____

Name of Emergency Contact for Patient: _____

Phone of Emergency Contact for Patient: () _____ - _____

Insurance Information

Type of Insurance: _____

Insurance Number: _____

Name of MCO: _____

Date Suboxone Notification Form Submitted (MPC only): ____/____/____

(Please attach copy of notification form if available)

Transfer Criteria

Patient Meets the Following Transfer Criteria (check all that apply):

- No withdrawal symptoms
- Minimal or no side effects of buprenorphine
- No longer has uncontrollable cravings for opioid agonists
- Compliant with independent medication administration for at least 2 weeks
- Compliant with counseling and treatment appointments
- Last toxicology test is negative for opioid use
- Patient tested positive for buprenorphine within the last 30 days

Drug Testing Results

Attach LAST urinalysis/tox screen results and buprenorphine UA/dip stick results to this form

Date of Last Tox Screen: ____/____/____

Drugs Detected in Last Tox Screen:

- None Cocaine Marijuana Benzodiazepines Alcohol Analgesics Stimulants
- Others: _____

Medical History

Intake physical and/or copy of latest H&P attached: Yes No

If NO, report medical history and current diagnoses: _____

Medications: _____

Allergies: _____

Psychiatric History

None Bipolar Disorder Major Depression OCD Schizophrenia PTSD

Anxiety Disorder Other: _____

Medications: _____

PCP Transfer Orders

Buprenorphine Prescription: _____ mg of buprenorphine _____ time(s) per day

Date of Last Rx: ____ / ____ / ____

Number of Tablets Prescribed in Last Rx: _____

Date Patient Will Run Out of Medication: ____ / ____ / ____

Recommended Follow-Up:

Frequency of Follow-Up PCP Visits: _____

Frequency & Duration of Counseling Sessions at Our Substance Abuse Treatment Program:

Signatures

Date: ____ / ____ / ____

Phone Number of Referring Physician: () _____ - _____

Name of Referring Physician (please print): _____

Signature of Referring Physician: _____

Phone Number of Treatment Counselor: ()____ - _____

Name of Treatment Counselor (please print):_____

Signature of Treatment Counselor: _____