

METHADONE MAINTENANCE PATIENT TREATMENT RECORD

PRIVATE AND CONFIDENTIAL

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

DATE OF BIRTH (MM/DD/YYYY):

GENDER:

MALE

FEMALE

CITY OF RESIDENCE:

HEALTH INSURANCE INFORMATION

DO YOU HAVE INSURANCE?

YES

NO

IF SO, PLEASE COMPLETE THE FOLLOWING, WHERE APPLICABLE:

ONTARIO CARD #:

OTHER PROVINCIAL CARD #:

PROVINCE:

I HAVE DISCUSSED WITH MY METHADONE PRESCRIBER AND I CONSENT TO THE FOLLOWING:

- The College of Physicians and Surgeons of Ontario will respect the confidentiality of my medical information
- The College of Physicians and Surgeons of Ontario will maintain the information in a database
- The use of information on this form will be used for statistical purpose

PATIENT'S SIGNATURE:

DATE (MM/DD/YYYY):

HAS THIS PATIENT BEEN ON A METHADONE PROGRAM BEFORE?

YES

NO

INITIATION INFORMATION	DATE PATIENT IS STARTING TREATMENT WITH YOU (MM/DD/YYYY):
	PRACTICE TYPE: INDEPENDENT GROUP PRACTICE CORRECTIONS
	NAME OF THE TREATMENT SITE:
	THE TREATING PHYSICIAN'S NAME IS:
	PHYSICIAN'S SIGNATURE: TELEPHONE #:

CESSATION INFORMATION	DATE OF LAST DOSE UNDER YOUR CARE IS (MM/DD/YYYY):
	REASON FOR CESSATION:
	NAME OF THE TREATMENT SITE:
	PHYSICIAN'S SIGNATURE: DATE: (MM/DD/YYYY):