

Organization Contact Person: _____

Program: _____

Telephone: _____

Fax: _____



Patient details (completed by organization staff)

Name of pt: _____

Date of birth: _____

Admission date to program: _____

Does patient have any one of the following?

☐ Opioid Use Disorder ☐ Alcohol Use ☐ Other _____ ☐ N/A

Does organization recommend the Medication-Assisted Treatment for this pt?

☐ No ☐ Vivitrol ☐ Buprenorphine

Reason for today's visit:

☐ Routine medical clearance (including H&P and labs)

☐ MAT ☐ TB TEST ☐ OTHER: _____

☐ Evaluation/ Follow up of medical issues: _____

☐ Referral (dental, optometry etc) _____

Please list any current medications (attach medication sheet if needed)

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Please check if completed at VFC appointment (completed by provider or coordinator).

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|--|
| <input type="checkbox"/> TB Test placed today |
| <input type="checkbox"/> Read TB test by _____ |
| <input type="checkbox"/> Physical Exam completed |
| <input type="checkbox"/> Labs drawn |
| <input type="checkbox"/> Meds dispensed at VFC |
| <input type="checkbox"/> Rx given to pt |
| <input type="checkbox"/> |

A summary of today's visit will be indicated in the patient plan in which the patient will receive when they see a discharge coordinator at VFC.

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