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|  | MEDICALLY ASSISTED THERAPY  TRANSFER/TRANSIT FORM | FORM 3G VER. APRI. 2023 |

**County.................................................. Sub-County............................................. Site/ Facility....................................**

**Date (DD/MM/YYYY) .......................................……………………. MFL Code...................................................... Implementing Partner…………………………….……………………………………………………………..........................**

Name: …………………………………………………………. MAT ID NO. ……………………………………... Sex ………………………

Date of Birth……………………………………. Treatment supporters Name ………………………………………………………

Telephone No……………………………………… MAT clinic Enrolled in …………………………………………………………

MAT enrollment Date…………….………...………… Referral Date (DD/MM/YYYY) …………………………………….…

Type of movement: Transfer Transit Other Referral (Specify): ………………………..……………..

From (Referral Site) ................................................. To (Dispensing Site) …………………………………………...

**Reason for Transfer/Transit** (Transit not exceeding 30 days **Transfer if more than 30 days**)**:**

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**Clinical & drug use History:**

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**Psychosocial background & concerns:**

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**Laboratory Investigations done & date:**

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**Vaccinations done & date**

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**Diagnosis:**

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Current Methadone/Buprenorphine dose……………………………Date & Time last administered ……………………….

Other medication………………………………………………………………………………………………………………………………………

Clinician………………………………………………... Signature ………………….………... Date …………………………….

MAT Clinic Lead …………………………………………………… Signature …………………………. Date ……………………………