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|  | MEDICALLY ASSISTED THERAPY  INVOLUNTARY DISCONTINUATION FORM | FORM 3H VER. APR. 2023 |

**Date (DD/MM/YYYY) ........................................…….…………….**

Name of Client: ……………………………………………………... MAT ID No. ……………………………………………………

Date enrolled: ……………………………………………………...

Date commenced on involuntary discontinuation: ………………………………………………………

**Reason for discontinuation (Tick all that apply)**

High risk of drug overdose due to frequent intoxication with alcohol and other drugs, overdose incidents despite repeated client education

Verbal or physical violence or threatened violence to other clients or staff

Drug possession or dealing around the clinic or institution

Carrying weapons around the clinic or institution

Diversion of methadone or buprenorphine.

Property damage or theft from the clinic or institution

Repeated unacceptable disruptive behavior around the clinic or institution

Other ………………………………………………………………………………………………………….

**Recommended discontinuation plan:**

Abrupt cessation

rapid taper

gradual taper

Follow up plan………………………………………………………………………………………………………………………………………………

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**Treatment team.**

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| --- | --- | --- | --- | --- |
| **Designation** | **Name** | **Organization** | **Signature** | **Date** |
| MAT Clinician |  |  |  |  |
| MAT Counselor |  |  |  |  |
| CSO Clinician/Counselor |  |  |  |  |