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|  | MEDICALLY ASSISTED THERAPY  VOLUNTARY DISCONTINUATION REQUEST FORM | FORM 3I VER. APRI. 2022 |

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

I (*name, UIC*) …………………………………………………………………………….…... **Voluntarily** request to have my MAT treatment discontinued from *(name of MAT Clinic)* …………………………………………………………………………………. with effect from (*Date*)……………………………………………..........

I have reached this decision on my own volition and I have discussed the reasons as well as possible complications of this decision with my primary counsellor and the MAT clinician.

**I wish to request for (tick one);**

Abrupt cessation

Accelerated taper

Gradual taper of my methadone/buprenorphine dose.

**Reasons for Discontinuation:** …………………………………………………………………………………………………………..

I understand that upon completion of the dose taper, any request to join the MAT program will be treated as a re‐induction and hence will follow the laid down procedures.

Client Signature or left thumb print: ………………………………………………….…………...…... Date: ……………………………

Counselor Name: ………………………………………...……… Signature…………………………… Date: ……….………………….

Clinician Name: ………………………………………………… Signature………………………………… Date: ………….………………