Cran
Centre de recherche et d'aide pour narcomanes

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PERMANENT TRANSFER

❒ Interservice ❒ Interregional ❒ Interprovincial ❒ International

PATIENT IDENTIFICATION

Name:	First name:	**Language**: E❒ F❒ Gender: F❒ M❒
Address:	City:	Postal code:
Date of birth*:	RAMQ card #*: Expiry date /	Telephone: ( )

*** Compulsory fields**

PHYSICIAN IDENTIFICATION

Stamp	Name:	
	Address:	
	City:	
	Telephone:	Fax:

REASON FOR TRANSFER

❒ Moving ❒ On statutory release ❒ Disorganization (specify which type): ______________________________

Information on opioid dependence treatment follow-up:

Follow-up intensity: one appointment per ____________________

Shows up for appointments as expected? ❒ yes ❒ no

History of overdose in the past year? ❒ yes ❒ no

Comfort dose: has it been reached? ❒ yes ❒ no

Disciplinary actions imposed in the past year? ❒ yes ❒ no

Physician's recommendation:

Transfer patient to**:** ❒ **Primary care (1st line)** ❒ **Specialized centre or CRD** ❒ **Low threshold** Specify: ____________________

____

Transfer to: ________________________________ on: ________________________________
City, region, province or country Expected date of transfer

PRESCRIPTION

METHADONE Current substitution treatment started on ______/______/______
Y M D

Prescription valid from ______/_____/______to ______/______/______ (inclusively)
Y M D Y M D

Patient is administered ____________ mg per day

Number of unsupervised doses at a time: ____________ Number of days patient goes to pharmacy:____________/7

BUPRENORPHINE (SUBOXONE®) Current substitution treatment started on: ______/______/______
Y M D

Patient is administered ____________ mg per day __________ mg every 2 days

Patient is administered ____________ mg every 3 days i) __________ mg ii) __________ mg iii) __________ mg

Number of unsupervised doses at a time ________________ Number of days per week patient goes to pharmacy: _____________/7

Pharmacy:

Address:

Telephone: ( ) Facsimile: ( )

OTHER PRESCRIBED MEDICATIONS

Name	Dosage	Name	Dosage

IMMUNIZATIONS (PLEASE TICK APPROPRIATE BOXES)

	Completed	In progress		Completed	In progress	Specify:
Hepatitis A	❐	❐	Fluviral®	❐	❐	
Hepatitis B	❐	❐	Others	❐	❐	
Pneumovax	❐	❐				

HISTORY

Medical and surgical history, allergies:

Psychiatric diagnoses:

Has the patient received a specialized psychiatric evaluation? ❐ yes ❐ no

CURRENT CONSUMPTION OF OPIATES AND/OR OTHER SUBSTANCES (METHOD OF ADMINISTRATION AND FREQUENCY)

COMMENTS

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRAN to release the information on this form to the physician (or centre) who (which) might accept my transfer.

Signature of beneficiary:	Date:
Signature of witness at signing:	Date:
Verbal authorization: ❐	Date:
Signature of physician:	Date: