MEDICATION ASSISTED TREATMENT (MAT) STATUS REPORT FORM

This form is used to provide progress updates between the MAT Prescriber and the ADTC Treatment Liaison.

Client’s Name: ______________________________________

MAT Medication: ☐ Suboxone ☐ Vivitrol/ Naloxone ☐ Methadone

Current Dosage: _________________________________

How often does Client meet w/ Prescriber: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ____

Next Appointment w/ Prescriber: ________________________

Frequency of Dose: _______________________________

Missed Dose(s): ________________________________

Does the participant have carry privileges: ☐ Yes ☐ No

If yes, frequency of medication checks: _______________________________

Any issues with medication checks: ________________________________

Urinalysis status – are their samples in compliance with medication dosage: ☐ Yes ☐ No

If no, please provide detailed urinalysis information: ________________________________

Has the participant missed any appointments: ☐ Yes ☐ No

If so, is the participant at risk of program failure: ________________________________

Comments/Concerns: __________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Prescribing Agency:_________________________________

Prescriber Name: ___________________________________

Authorizing Signature: ______________________________

Date of report: _____________________________________

PLEASE FAX OR EMAIL THIS COMPLETED FORM TO:

☐ Center For Human Services  Andrea Nollau
   anollau@chs-nw.org
   Phone: 206-362-7282            Fax: 206-362-7152

☐ Catholic Community Services  Saundra Rose-Moore
   SaundraRM@ccsww.org
   Phone: 425-595-6776            Fax: 425-258-5275