BUTTERFLY HOUSE FOR WOMEN

A home for women in spiritual recovery from alcoholism and addiction

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MAT/MAR SUPPLEMENTAL APPLICATION

Please check that you have signed a release of information authorization with your MAT prescriber/doctor/provider that will allow us to speak with him/her. ☐

Name: _____ Date: _____

Type of MAT: _____ Dosage: _____

Form (injection, wafer, strip, tablet, liquid, etc.) _____

How many times a day? _____ Time(s) of day: _____

Clinic name and location: _____

Prescriber: _____

Does your prescriber provide regular medical monitoring for blood pressure, etc?

_____

Does your prescriber require regular counseling or group sessions while you are prescribed MAT?

_____

If your MAT is dispensed daily by a clinic or if your prescriber requires regular attendance at groups or counseling, do you have a plan for transportation to and from the dispensary or clinic? _____

If so, what is that transportation plan? _____

_____

When did you begin MAT? _____

What are your long terms goals concerning MAT? _____

_____

If you have ever missed a dose of your MAT, how did you react, physically and emotionally?

_____

Do you have a tapering plan? _____ if so, what is that plan? _____

_____

_____

Does your provider/prescriber support your taper plan? _____

Does your provider/prescriber offer supports to mitigate withdrawal symptoms if you were to taper off your MAT? _____

If so, what type of supports: _____

Do you feel MAT would prevent you from full participation in a 12 Step program?

_____

_____

Is there additional information you would like to add: _____

_____

_____

I certify that all information provided in this application is true.

Signature: _____ Date: _____

MAT SUPPLEMENTAL PROCESS CHECKLIST:

completed MAT supplemental application _____

weekly security surcharge for prescription opioids kept in the home $(_____)

(1/11/19)