Transfer Summary

Client Name: _____ **Date of Birth:** ___/___/___

Address: _____

_____

_____

Length of Time in Treatment: _____

Physical and Mental Health Problems: _____

_____

CURRENT MEDICATIONS

Methadone: _____

Dispensing Arrangements: _____

Other Medications: _____

VIROLOGY	DATE TESTED	RESULT
HIV		
HEP B		
HEP C		
HEP A		
HEP B post vaccination anti bodies		

VACCINES:

Hep A 1st _____ 2nd _____ 3rd _____

Hep B 1st _____ 2nd _____ 3rd _____

Hep A&B 1st _____ 2nd _____ 3rd _____

Drug Screen for last month attached: YES ☐ NO ☐

Any other information: _____

_____

_____

Signed: _____ **Date:** _____