# Appendix 17: Inter-service transfer request

The following sample form is to be used by opioid substitution treatment (OST) services when transferring a client to another such service.

The referring service is also expected to provide a comprehensive assessment, a current risk assessment, a summary of treatment and a current treatment plan to the new service as part of the transfer documentation.

|  |  |
| --- | --- |
| Date: |  |
| New specialist service: |  |
| Contact name: |  |
| Phone no: |  |
| Email: |  |
| Referring specialist service: |  |
| Contact name: |  |
| Phone no: |  |
| Email: |  |

## Client’s personal details

|  |  |
| --- | --- |
| Name: |  |
| Date of birth: |  | NHI: |  |
| Current address: |  |
| Phone: |  | Fax: |  |
| Other: |  |
| Requested destination: |  |
| Intended address: |  |
| Intended phone: |  |
| Other relevant details: |  |

## OST medication details

|  |  |
| --- | --- |
| Current OST medication and dose: |  |
| Takeaway arrangements: |  |

## Monitoring/review information

|  |  |
| --- | --- |
| Length of time with OST service: |  |
| How often seen at the clinic (eg, monthly, every three months, every six months): |  |
| Current scripting arrangement: |  |
| Recent laboratory screen date and results: |  |
| Last clinical review date: |  |
| Risk features identified: |  |

## Mental health and medical information

|  |  |
| --- | --- |
| Current GP and contact details: |  |
| Medical issues identified: |  |
| Medical health issues identified: |  |
| Diagnoses: |  |
| Prescribed medications: |  |
| Follow-up required: |  |
| Other information: |  |

## Reason for transfer

|  |
| --- |
|  |

## Other relevant details

|  |
| --- |
|  |

## For new service

|  |  |
| --- | --- |
| Allocated key worker: |  |
| Received: | ⬜ Comprehensive assessment⬜ Risk assessment⬜ Summary of treatment⬜ Treatment plan |

Adapted from Christchurch Methadone Programme documentation.