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| **IDENTIFICATION DU PATIENT** | | | | | | | | | | | | | | | | | | | | | | |
| Nom : | | | | | | | | | | | Prénom : | | | | | | | | | | | |
| Langue :  F  A | | | | | | Sexe : | |  | |  | |  | | | | | | | | | | |
| Adresse : | | | | | | | | Ville : | | | | | | | | | | | Code postal : | | | |
| DDN\* : | | | | | NAM\* : | | | | | | |  | | / | |  | | | Téléphone : | | | |
| **\*champ obligatoire** | | | | | | | | | | | date d’expiration | | | | | | | | | | | |
| **IDENTIFICATION DU MÉDÉCIN** | | | | | | | | | | | | | | | | | | | | | | |
| Étampe | | | | | | | Nom : | | | | | | | | | | | | | | | |
| Adresse : | | | | | | | | | | | | | | | |
| Ville : | | | | | | | | | | | | | | | |
| Téléphone : | | | | | | | | | | Télécopieur : | | | | | |
| **MOTIF DE TRANSFERT** | | | | | | | | | | | | | | | | | | | | | | |
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| Enceinte , date des dernières menstruations :       /      / | | | | | | | | | | | | | | | | | | | | | | |
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| Intensité du suivi : un rendez-vous par | | | | | | | | | | | | | | | | | | | | |  | |
| Dose de confort atteinte ? | | | | | | | | | | | | | | | | | | | | |  |  |
| Se présente à ses rendez tel que prévu : | | | | | | | | | | | | | | | | | | | | |  |  |
| Mesures disciplinaires dans la dernière année : | | | | | | | | | | | | | | | | | | | | |  |  |
| Antécédent de surdose dans la dernière année : | | | | | | | | | | | | | | | | | | | | |  |  |
| **Recommandation du médecin :** Transfert du patient vers : | | | | | | | | | | |  | | | |  | | | | | |  | |
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| Précisez : |  | | | | | | | | | | | | | | | | | | | | | |
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| Transfert vers : | |  | | | | | | | | | le : | |  | | | | | | | | | |
|  | | Ville, région, province ou pays | | | | | | | | |  | | Date prévue de transfert | | | | | | | | | |

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| **PRESCRIPTION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Méthadone** | | | **Buprénorphine** | | | | **Morphine 24h** | | | | | | | | | | **Autre :** | | | | | | | | | | | | |
| Date d’entrée de traitement : | | | | | | /      / | | | | | | | |  | | | | | | | | | | | | | | | |
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| Date RX en cours : du | | | | | | /      / | | | | | | | | au | | | | /      / | | | | | (inclusivement) | | | | | | |
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| Reçoit :       mg par jour OU préciser si autre fréquence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nombre de doses non supervisées à la fois : | | | | | | | | | | | | | | Nombre de jours à la pharmacie par semaine :       / 7 | | | | | | | | | | | | | | | |
| **Buprénorphine injectable** | | | | | mg | | | | | Date de la dernière administration | | | | | | | | | | | | | | | /      / | | | |
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| **APPROVISIONNEMENT PLUS SÉCURITAIRE** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Hydromorphone       mg | | | | | Autre : | | | | | | | | | | | | | | | | | | | | | | | |
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| Nombre de comprimés par jour : | | | | | | | | | | | | | Nombre de comprimés maximum par service : | | | | | | | | | | | | | | | |
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| Pharmacie : | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Adresse : | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Téléphone : | |  | | | | | | | | | | | | | | Télécopieur : | | | | |  | | | | | | | |
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| **AUTRES MÉDICAMENTS PRESCRITS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nom : |  | | | Posologie : | | | |  | | | | | | | Nom : | | | |  | | | | | Posologie : | | |  | | | |
| Nom : |  | | | Posologie : | | | |  | | | | | | | Nom : | | | |  | | | | | Posologie : | | |  | | | |
| Nom : |  | | | Posologie : | | | |  | | | | | | | Nom : | | | |  | | | | | Posologie : | | |  | | | |
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| Si possible, joindre profil pharmaceutique. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ANTÉCÉDENTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Médicaux et chirurgicaux, allergies :** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| **Psychiatriques (diagnostic, évaluation spécialisée) :** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **CONSOMMATION ACTUELLE D’OPIOÏDES ET/OU AUTRES SUBSTANCES (MODE ET FRÉQUENCE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **COMMENTAIRES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **MEDECIN DE FAMILLE** | | |
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| **Signature complète**, |
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Faire parvenir le présent formulaire par télécopieur 514-527-0031 ou

par courriel rvcran.ccsmtl@ssss.gouv.qc.ca avec objet "Transfert"

Pour toute question: Téléphone 514-527-6939 poste 2224 Sans frais : 1-866-726-2343