Medication Assisted Treatment Last Dose and Continuing Care Letter

Patient Name: _____ DOB: _____

The above patient last received _____ dose(s) of _____ mg **Methadone / Suboxone / Subutex** (circle one)

on _____ (date) to be administered from _____ to _____ (dates).

Upon completion of treatment at Valley Vista, this provider **will / will not** (circle one) continue to provide medication assisted treatment services to this patient.

Prescriber: _____ Practice Name: _____

Phone: _____ Fax: _____

Medical Staff Signature: _____

PLEASE FAX COMPLETED FORM TO ATTENTION: NURSING at 802-222-5901