

CONFIRMATION OF WITHDRAWAL STATUS

Patient's Name/ DOB: _____

Following examination are you able to give clearance that the applicant is not currently experiencing any withdrawal symptoms? Yes No

Comments: _____

Have you assisted this patient with withdrawal? Yes No

Comments: _____

Period of time that they have been monitored for withdrawal: _____

Medications required to treat withdrawal symptoms including last dose and date taken:

Please Note:

If your patient is on any additional medication, complete the Medical Profile attached. Your patient will need to admit with seven (7) days medication.

Please also note that the labelling on the medication and prescription replicate what is written on the Medical Profile document.

Signed: _____

Name: _____

Date: _____

Position: _____

Title: _____