Washington State Health Care Authority

Fax this form to: (425) 249-7458

Spoke Care Navigator Phone (425) 404-1155

Hub and Spoke Network

Medication Assisted Treatment (MAT) Referral Form

PATIENT INFORMATION

Referral Date:_____ Patient Name: _____

DOB: _____

Phone number: _____

Alternate contact name: _____

Alternate contact number: _____

☐ Patient received first dose of buprenorphine/naloxone (Suboxone) in the ED

☐ Patient was given a phone and the new phone # is_____

☐ Patient has received patient handout "*What you can expect* "

REFERRING PROVIDER INFORMATION

Referral Source: ☐ Emergency Department ☐ EMS ☐ Other_____

Referring facility: _____

Referring provider (please print name): _____

Phone: _____

Comments: