Fax this form to: (509) 232-5778

Spoke Care Navigator Phone (509) 499-8809

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 Phone # ____________________

☐ 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: