Traverse Health Clinic Recovery Program

MAT Re-Entry Application

Patient Name: _____

DOB: _____ **Date**: _____

1. Why are you interested in restarting medication assisted treatment (MAT) at this time?
   _____
   _____
   _____

2. When were you discharged from medication assisted treatment at Traverse Health Clinic?
   _____ Reason for discharge? _____

3. Have you received medication assisted treatment through another provider?_____
   If yes, please list the provider _____
   When did you receive medication assisted treatment through this provider?
   Start date: _____ End date: _____
   Reason discontinued: _____

4. Why do you feel medication assisted treatment would be beneficial for your recovery at this time and was not previously?
   _____
   _____
   _____
   _____

5. What have you done that supports your recovery since your discharge from medication assisted treatment at Traverse Health Clinic?
   _____
   _____
   _____
   _____

6. Are you able to attend all of the required appointments for the Program? _____

   Patient Signature: _____
   Today's date: _____

*Completion of this application does not guarantee re-entry into the Recovery Program. Rev:10/23/19