Opioid Agonist Client Record Checklist

Date:

Agency Name: **Certification No.:**

Number of clients being dosed: **Number of clients on waiting list:** **Surveyor:**

Please list client(s) in alpha or numerical order:

Client ID 1: Client ID 2: Client ID 3:

Client ID 4: Client ID 5: Client ID 6:

Corresponding Client ID

1	2	3	4	5	6	3793:2-3-01	Licensure to conduct an opioid agonist program.
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Opioid Agonist Client Record Checklist (continued)

Agency Name: Certification No.:

Corresponding Client ID

1	2	3	4	5	6	3793:2-3-01	Licensure to conduct an opioid agonist program.
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Corresponding Client ID

1	2	3	4	5	6		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Opioid Agonist Client Record Checklist (continued)

Agency Name: Certification No.:

Corresponding Client ID

1	2	3	4	5	6	3793:2-3-01	Rationale for take-home doses including at a minimum:
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
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☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Opioid Agonist Client Record Checklist (continued)

Agency Name: **Certification No.:**

Corresponding Client ID

1	2	3	4	5	6		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Opioid Agonist Client Record Checklist (continued)

Agency Name: _____ **Certification No.:** _____

Corresponding Client ID

1	2	3	4	5	6		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		
☐	☐	☐	☐	☐	☐		

Comment(s):