



Process: OAT Assessment and/or Treatment – Out-of-Community Travel

To be eligible for referral to KIM Inc MMOP OAT Program, the following criteria must be met:

1. Participant must **want** to participate in the Opioid Agonist Therapy program
2. Must have an Opioid Use Disorder
3. Must be over the age of 18

When a medical professional has obtained client consent for Opioid Agonist Therapy (OAT) assessment and/or treatment, and the client is required to travel outside their community to access this service, complete the following steps:

1. **Contact MMOP Clinic**
Contact the MMOP Clinician to request a consultation and/or schedule an appointment at **204-259-9619 or 1-866-763-6667**.
2. **Submit Referral**
Once the client's appointment has been confirmed, fax the completed referral to MMOP at **204-201-2389**.
3. **Submit Travel Request to NIHB**
Provide an appointment letter or appointment details, along with the completed **NIHB Travel Request Form**, and forward these documents to the **NIHB Regional Office** for review.
4. **Forward NIHB Approval to MMOP**
Upon receipt of NIHB travel approval, fax a copy of the approval to the MMOP Office at **204-201-2389**.
5. **Notify Client**
Inform the client of the travel approval and provide them with MMOP appointment details and relevant information.
6. **Address Travel Issues**
If any issues arise related to travel requests, contact:
Amelia Sheocharan
Senior Manager, Non-Insured Health Benefits
✉ Amelia.Sheocharan@sac-isc.gc.ca
☎ 204-430-2783



PATIENT INFORMATION	
Last name:	Street address:
First name:	City/town/community:
MB Health #:	Postal code:
PHIN:	Can the patient travel to any of the below for OAT <input type="checkbox"/> Thompson
Date of birth (dd/mmm/yyyy):	
Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary phone number: Can we leave a confidential voice message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Two spirit <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer not to specify	Email:
	Social media handle:
	Preferred language: Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medical history (medications, allergies, psychosocial, etc) <input type="checkbox"/> Opioid Use Disorder <input type="checkbox"/> Type of Opioid use: _____	<input type="checkbox"/> Comorbid conditions (TB, Hepatitis, etc) <input type="checkbox"/> STBBIs <input type="checkbox"/> Pregnant
Does the patient self-identify as First Nations, Métis, or Inuit? <input type="checkbox"/> Status <input type="checkbox"/> non-status <input type="checkbox"/> Métis <input type="checkbox"/> Inuit	
Other patient characteristics (please check all that may apply):	
<input type="checkbox"/> Injects drugs <input type="checkbox"/> Has a history of substance use disorder <input type="checkbox"/> Was previously on Opioid Agonist Treatment (OAT)	<input type="checkbox"/> Lives in poverty and/or is experiencing houselessness <input type="checkbox"/> Justice Involved <input type="checkbox"/> Experiencing serious and persistent mental illness
Does the patient have accessibility needs that should be considered?	
<input type="checkbox"/> Mobility (wheelchair access, difficulty with stairs, etc) <input type="checkbox"/> Visually impaired <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Other: _____ <input type="checkbox"/> No accessibility needs	
Additional Information:	



Keewatinohk Inniniw Minoayawin Inc.

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94 Commerce Drive
Winnipeg, MB
204.202.8852
info@kimhealth.ca
kimhealth.ca

Provider Information

Referring Provider Name: _____

Phone Number: _____ Fax Number: _____

Primary care provider name (if different from above): _____

REFER PATIENTS BY FAX TO: 204-201-2389 or CONSULT: 1-866-763-6667 or 204-259-9619