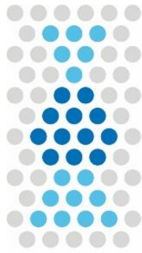

NEW YORK
MATTERS
Medication Assisted Treatment & Emergency Referrals

Data Collection for Hospitals

Please complete this data collection form if you intend on participating in the MATTERS network in the future. This does not commit you/your organization to participating, it simply allows for planning to continue. If your hospital/treatment organization has multiple locations, please complete one form for each location.

Facility Name ____

Address ____

Phone ______________________________

Contact Name ________________________ Contact Title __________________________

Contact E-mail (company email preferred) ____

Estimated number of waived (X number) providers _____ MD/DO ________PA/NP

Fax (must be in a secure location – for referring emergency departments, the fax

near the ER secretary/nurse's station is ideal) ______________________________________

Availability of peer support at your hospital/clinic? __________________________________

Additional comments/concerns:
____

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