



Reason for courtesy dosing (i.e. vacation, work, request for permanent transfer, residing in another facility, etc.)

Any relevant medical conditions/medications (i.e. breathalyzer testing)

**4**

## **Dosing Information**

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Dispensing start date      Dispensing end date      Date of patient's last dose (optional)

**Choose one:**      Methadone      Buprenorphine/Naloxone      Buprenorphine      Dosage:

Dosing schedule and take-home allowances. Specify on-site days.

Special Instructions (i.e. other observed medications, split dosing/frequency, etc.)

**Patient is informed of all fees and dosing hours:**      Yes      No

ICD 10 Diagnosis Code      Staff person making transfer request (print name)

Medical director or DEA registered provider signature

Date form is signed