REQUEST FOR COURTESY DOSING

To: IAA's Interior Medication Assisted Treatment Date: _____ /_____ /_____

Address: _____

Phone: _____ Fax: _____

Patient Name and ID# (if applicable): _____

Date of Birth: _____ /_____ /_____ SSN:_____

Patient identification information (height, weight, eye color, etc.) _____

_____

Form of ID to be presented by patient: _____

Courtesy dosing dates: Begin dispensing on _____ /_____ /_____ End dispensing on _____ /_____ /_____

Medication to be dispensed: _____

Take-home dose(s) authorized _____ Daily dosage _____mg

Verified by: _____ DEA#: _____
Staff name and title

Length of time at current dose: _____

Reason for courtesy dosing: _____

Your daily courtesy dosing fee of $ _____ has been explained to the patient.

IMAT dosing hours: M-F 6:30 a.m. to 9:30 a.m., Saturday 8:00 a.m. to 10 a.m., Sunday 8:30a.m. to 9:30 a.m.

Patient has been advised that your dispensing hours are: _____

_____

Comments: _____

_____

_____

_____ _____
Staff making request Medical Staff (Nurse or MD)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure without written consent of the person to whom it pertains.