Opioid Treatment Program – Guest Dosing Request Form

To be completed by the home clinic no later than 72 hours prior to initial guest dose.

Select Location:

☐Elmira OTP/Outpatient: 911 Stowell St, Elmira NY, 14901
- Phone: 607-737-5215
- Fax: 607-737-5219
- Email: otpclinicalelmira@casa-trinity.org

☐Olean OTP/Outpatient: 201 S Union St, Olean, NY, 14760
- Phone: 716-373-4303
- Fax: 716-373-4327
- Email: otpclinicalolean@casa-trinity.org

Referral Date: _____ Guest Dosing Dates: _____

Client Name: _____ DOB: _____SSN: _____

Address: _____

Phone Number: _____ Gender: _____

Home Clinic: _____ Clinic Address: _____

OTP Contact/Counselor: _____Clinic Phone #: _____

Reason for Guest Dosing: _____

Dosing Schedule/Number of Take-home Doses: _____

Methadone Dose: _____

Additional Information (e.g. behavioral concerns): _____

Please fax or email this form along with the following documentation to the location selected above:

- ☐ Active methadone order w/ Dr signature
- ☐ Substance use disorder diagnosis
- ☐ Description of clinical stability
- ☐ Current medication list
- ☐ Dosing history (past three months)
- ☐ Most recent EKG and lab work
- ☐ Last toxicology result
- ☐ Signed consent
- ☐ Signed guest dosing agreement

Please note:

- Dosing hours are Monday-Saturday 6:30AM-10:30AM (Must be in the building and checked in by 10:25am)
- Bring a photo ID
- Self-Pay: $10 per dose
- CASA-Trinity can bill your insurance for guest dosing. If you would like CASA-Trinity to do this, please provider:
    - Insurance Name: _____
    - Insurance ID: _____
    - **Please be aware that even if CASA-Trinity bills your insurance company, that does not mean they will pay (ex: insurance is out of network with CASA-Trinity). If your insurance does not pay, you will receive a bill at the rate of $10 per dose.**

Guest Dosing Agreement

By signing this document, I agree that I have read, understand, have been given an opportunity to ask questions, and agree to follow the conditions listed below as a guest receiving methadone at CASA-Trinity. I was given a copy of these expectations.

1. I understand that if I am receiving any take-home doses, I must bring a lockbox to safely transport and store the medication.
2. I understand that dosing hours are Monday-Saturday from 6:30am to 10:30am and that I must arrive at the facility no later than 10:15am.
3. I understand that I must provide a photo ID for staff to verify my identity.
4. I agree to treat staff and other patients with respect.
5. I agree to be appropriate while at the clinic. This includes not participating in the following behaviors: committing crimes on CASA-Trinity ground, harassment or bullying, loitering, arriving under the influence of drugs or alcohol, exchanging or passing any items (money, drugs, cigarettes, etc.), or diverting medication.
6. I understand the financial responsibility of $10 per dose. If I choose to have CASA-Trinity bill my insurance and my insurance does not pay, I understand I will be responsible and will receive a bill of $10 per dose.

_____ _____

Client Signature Date