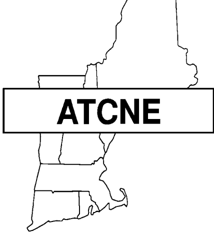

ADDICTION TREATMENT CENTER OF NEW ENGLAND, INC.

77 "F" WARREN STREET • BRIGHTON • MASSACHUSETTS • 02135
CLINIC (617) 254-1271
BUSINESS FAX (617) 782-7668

COURTESY METHADONE MEDICATION (TEMPORARY TRANSFER) APPROVAL FORM

1. **Is this an Emergency (< 14 days)? Yes_____ No_____** (Emergencies require 24-48 hours lead time)
   Reason: ☐ **Sudden Illness/Death of Family Member** ☐ **Domestic Violence**
   ☐ **Other (describe)**
   ____
2. **Is this a Planned Event up to 28 days (14 days + 1 extension)? Yes_______ No_________**
3. **Is this a Short-Term Residential Placement request (up to 45 days)? Yes_______ No _________**

Client Name: ____ D.O.B: ____________

Client Contact Phone: ______________________________ Cell Phone: ________________________

Payer or Insurance: ____

Sending Program (Home) Name: ______________________________ ________________________
Program Address: ________________________________ Fax number: ____________________________
Contact Name: ___________________________Phone Number:_________________ Ext: __________________

Receiving Program (Guest): Name:____
Program Address: __________________________________ Fax number: _______________
Contact Name: __________________________Phone Number: __________________ ext: ____

Dear Sending Program: Certain requirements must be met in order for us to treat your client. This completed form and all information must be received by fax five (5) weekdays prior to your client's first day with us in order to be approved.

1. **Signed release of confidential information form**
2. **Current medication list**
3. **Last Drug Screen (<u>Short -Term Residential requires 2 Drug Screens</u>)**
4. **Recent EKG if dose > 150 mg? Yes_______ No________**
   (Not required in Emergency)

Client's current methadone dose __________________

____
Physician or Nursing Signature

Last Day at Sending Program __________________

Number of take-outs for travel ______________________

First Day at Receiving Program __________________

Number of take-outs for travel ______________________

Return Date Sending Program __________________

Is the client pregnant? Yes_____ No______

Please verify:
_______ Client is neither in the induction phase nor in medically supervised withdrawal.
_______ This client is not currently on a split-dosing protocol
_______ This client will be returned to his/her home clinic at the end of the approved guest medication dates. Any extensions must be approved by the receiving clinic.
_______ There is no evidence that this client is currently using illicit benzodiazepines
_______ The client is sufficiently stable for courtesy methadone medication

Other relevant information: (allergies, identifying information, other) ____
____

Clinical or Medical Supervisor Signature: ____ Date_____________________

<u>Please note that the client is to bring</u>: (1) last-dose letter; (2) photo ID; (3) insurance card/fees.
Medication Dispensing Hours:
Monday _________Tuesday_________ Wednesday_________ Thursday_________ Friday_________ Sat./Sun.___________