Finger Lakes Area Counseling & Recovery Agency
FLACRA™
Together, we will.

METHADONE GUEST DOSE REQUEST

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

TREATING FACILITY:

FLACRA
Geneva CCBHC/OTP
116 Lewis St. Geneva, NY 14456
315-781-0771 | 315-781-2773

Referral Date: _____ Guest Dosing Dates: _____

Client Name: _____ DOB: _____ SSN: _____

Address: _____

Phone Number: _____ Gender: _____

Home Clinic: _____ Clinic Address: _____

OTP Contact/Counselor: _____

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