Washington State Health Care Authority

Request for Courtesy Dosing

Please fill out completely and legibly
Please include signed ROI and state photo ID

Home Clinic Information			
TODAY"S DATE Click or tap to enter a date.	Name of home OTP		
Address	City,	State	Zip
OTP main phone number/Fax	OTP dispensary direct phone number	OTP Dispensary direct Fax number	
TO (or, Receiving Clinic)			
Name of Receiving Clinic			
Address	City,	State	Zip
OTP main phone number/Fax	OTP dispensary direct phone number	OTP Dispensary direct Fax number	
Dose Verified By	Title		

Patient Demographics			
Patient Clinic ID Number	First name	Last name	Middle Initial
Date of Birth	Social Security number	Gender: ☐ Female ☐ Male ☐ Other	If Female, pregnant? ☐ Yes ☐ No
Reason for Courtesy Dosing (i.e. vacation, work, request for permanent transfer, etc.):			
Any relevant medical conditions/medications			
Is patient on daily or random breathalyzer testing? ☐ Yes ☐ No Frequency			

Dosing Information	
Dispensing **START DATE** Click or tap to enter a date. Dispensing **END DATE** Click or tap to enter a date.	
Choose one Methadone Dosage Take-Home Doses Authorized? ☐ Yes ☐ No Dosing Schedule	
Special Instructions (i.e. other observed medications, split dosing, etc.)	
Patient is informed of all fees and dosing hours ☐ Yes ☐ No Patient Primary Insurance Choose one Medicaid *If receiving clinic is contracted with Medicaid, no fees are to be collected from Medicaid patients.*	Pt. Diagnosis code
Staff person making transfer request (print name)]	Medical Director or SAMHSA-approved prescribing delegate
Medical Order Written Click or tap to enter a date.	