NEW DIRECTIONS HEALTH CARE
306 West 11th St, 2nd Floor
Erie, PA 16501
Phone: (814) 240-6216 Fax: (814) 240-6219

GUEST DOSING INFORMATION

Patient's Name: _____

Patient's Address: _____

Patient's Phone Number: _____

Date of Birth: _____ Social Security Number: _____

Medical Insurance Carrier Name: _____

Medical Insurance ID#: _____

Gender: _____ Marital Status: _____ Race: _____

Height: _____ Weight: _____ Eye Color: _____

Hair Color: _____

Emergency Contact Name: _____Phone#: _____

Treatment Admission Date: _____

Was Client a Transfer to you: _____

If Yes: What was the Transfer date: _____

Current Methadone Dose: _____

Dates to be Dosed: _____

ALONG WITH THIS GUEST DOSING FORM:
PLEASE SEND PATIENT'S DRUG SCREENS FOR THE PAST 30 DAYS,
DOSAGE HISTORY FOR THE PAST 30 DAYS,
AND A **SIGNED ORDER FROM THE DOCTOR.**

Referring Counselor: _____

Treatment Center Name: _____

Treatment Center Address: _____

Treatment Center Phone Number: _____

Treatment Center Fax Number: _____

Treatment Center Physician's Name: _____

Dosing Fees	**Dosing Hours**
$25 intake fee	**Mon.- Fri. - 5:30am-10:00am**
$16 per day dosing fee	**Sat.- Sun./Holidays - 6:00am-9:00am**