WHITNEY YOUNG HEALTH
HEALTHCARE DESIGNED AROUND

4-10 DEWITT STREET, ALBANY, -NEW YORK 12207-1306
Phone: 518-463-3882◆ Fax: 518-591-4542

Welcome to the Opioid Treatment Program at Whitney Young Health Center. For your convenience, the following letter outlines information that you will need to send us when requesting that your patient guest dose at our clinic. This letter also provides information that will be helpful for your patient to know prior to their first day of guest dosing. If at any time you have any questions, please do not hesitate to contact the clinic at 518-463-3882, and ask to speak with the nurse in charge of guest dosing.

Providers:

- Please make sure that you complete the attached "Guest Dosing" form in its entirety with both the counselor and client signature. In order to complete this request in a timely manner, all information provided must be accurate. Failure to complete the form in its entirety can cause a delay in this process and/or denial of your guest dosing request.

- Please attach a CURRENT copy of the Doctor's Orders with the current dose amount.

- Please be aware that our facility is open Monday- Friday from 6:30am to 10:30am and 12:30pm to 3:00pm AND on Saturday from 6:30am to 10:30am. We are CLOSED on Sunday. Please go over our hours of operation with your client.

- If your facility is open 7 days a week, you will need to provide a Doctor's Order for a Sunday take home medication. If the patient will be Guest Dosing during a holiday, a current written order for take home medication will also be needed.

Clients:

- On your first day of medicating as a Guest at our clinic, please arrive at 8:30am. Due to our registration process, please arrange to be at the clinic for at least an hour.

- Payment of $10.00/day to Guest dose is expected to be paid in full in advance. Payments can be made in cash only.

- If you have a current bill with the clinic, any past due balance will need to be paid before you can receive your first dose.

- While you are guest dosing at the clinic, we ask that you follow all of the rules and regulations of the program. A Patient Handbook will be provided to you on arrival. If at any point during your episode of Guest Dosing at our clinic you are asked to leave due to behavioral issues, your home clinic will be notified and you will have to make arrangements to Guest Dose elsewhere.

Sincerely,
Megan Zacher, LCSW
Program Director

-

4-10 DEWITT STREET, ALBANY, -NEW YORK 12207-1306
Phone: 518-463-3882◆ Fax: 518-591-4542

Guest Dosing Referral - Methadone Maintenance Treatment Program

4-10 Dewitt Street, Albany, New York 12207-1306 • Phone (518) 463-3882 Fax (518) 591-4542

Date: _____

Name:_____ DOB: _____SS#: _____ State ID#: _____

Description: Sex: _____ Height: _____ Weight: ____lb. Hair: _____ Eye: _____

Race: _____ Other: _____

_____

Patient Address:

_____

Staff Contact Name: _____ Phone:

_____

Program:

_____

_

Program Address:

_____

City, State, & Zip Code:

_____

Program Telephone: _____ Program Fax:

_____

Clinic Hours:

_____

Purpose of visit: ( ) Vacation ( ) Working ( ) Emergency ( ) Other

_____

Date arrival: _____ Date of departure: _____ Transfer ( ) Yes ( ) No

Address while attending clinic:

_____

_____

_____

Telephone ( ) _____ and/or Cell phone ( )_____

*****PLEASE SUBMIT COPY OF MD ORDER FOR CURRENT DOSE AMOUNT*****

-

4-10 DEWITT STREET, ALBANY, -NEW YORK 12207-1306
Phone: 518-463-3882◆ Fax: 518-591-4542

****

****

The following to be completed by WMY nursing staff upon arrival:

Date: _____ Dose: _____ Blind dose: ( ) Yes ( ) No

Last date medicate: _____ Pick up schedule: _____

Medications: _____ Allergies:

_____

Medical Staff verifying dose: _____

Medical staff receiving information: _____

****

****

WMY MMTP medicating hours: Monday – Friday 8am-10 am and 12:30 – 3 pm Saturday 8am-10:30am. **Client must have a locked box**. We are CLOSED Sunday and some Holidays.

Guest Fee: $10 per day **Cash only**

If client is interested or planning to transfer to this clinic all inquiries regarding this should be communicated to the Clinical Supervisor/designee only.

PLEASE review the above information and sign below

_____ _____

_____

Client's Signature **Facility Representative** **Date**

Rev. 102017/jp

-