

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: _____

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Race: _____

Social Security Number: _____

Emergency Contact Name & Number: _____

Treatment Admission Date: _____

Methadone Dose: _____

Dates to be Dosed: _____

**Please Send the Following Client Information: Identification, last 3 drug screens,
30 days of dosing history, signed doctors order.**

Referring Counselor: _____

Treatment Center Name: _____

Treatment Center Address: _____

Treatment Center Phone Number: _____

Treatment Center Physician's Name: _____

Treatment Centre Physician's Signature: _____ Date: _____

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