MAT Program requesting:

☐ Janus Community Clinic
1000A Emeline Ave.
Santa Cruz, CA 95060
PH: 831-425-0112
F: 831-425-1847

☐ Janus South County
284 Pennsylvania Ave. Suite 1
Watsonville, CA 95076
PH: 831-319-4200
F: 831-319-4204

MAT Program
Temporary Transfer Request/Courtesy Dose

Date ________________

Patient _______________________________ ID ______________ DOB _____________ Admit Date _________________

SS#________-_______-_______ Method of payment: M-C ___Fee ___ if fees are not current, patient must see Front Office Coordinator for payment before paperwork can be completed.
Male ____ Female ____ Height _________ Weight __________Hair color __________ Eye color _________
Start date _________________________ End date ____________________
Reason ____
Clinic Name ____________________________________ Address ____
City ___________________________ State ______________ Zip ___________
Phone (   ) _____________________ Fax (   ) ______________________________
Contact Person/Title ____________________________________ Ext _________________ Fax ________________________

Written consent to release this information for the stated purpose and for the time needed to complete the same is hereby provided. Re-disclosure is prohibited.

Patient signature ____________________________________ **Date** _________________

Counselor Complete the following host program and patient information before approval.

Patient's program status ___ Excellent___ Good ___ Acceptable ___ Marginal ___ Troubled
Program requested to take UA? ___ No ___ Yes How Many? _____
Program requested to provide Take-Homes? ___ No ___ Yes How many? _____
Other medication (s) taken by patient ____ none ____
Other special instructions _____ none ____
Last positive UA result ____________________________________

Counselor signature ________________________________ **Date** ______________________

Nurse Complete the following host program and patient information before approval

Methadone Dose _______ **mgs Step Level** ______

Nurse signature _________________________________ **Date** _________________

Program Physician authorized the dosing of the above patient at the specified clinic at __________mgs and according to the scheduled arrangements.

____ ________________________
Dr. William Morris, Medical Director Date

Transfer Program's Physician concurs with and accepts this patient with methadone dose at ______ mgs.

___________________________________ ______________________________________ ____________
Signature of Program Physician Printed Name of Program Physician Date