Lakeland Centres
3506 Lakeland Hills Blvd
P.O. Box 90457
Lakeland, FL 33804
Tel. (863) 687-9900
Fax (863) 683-9180

Guest/ Courtesy Dose Form

Date: _____

Patient Name_____ ID#_____ DOB_____

Male Female SS#_____ DL#_____ State_____

HT:_____ WT:_____ Hair Color: _____ Eye Color: _____ Race: _____

Guest /Transfer Dosing Information:
Date last medicated in home clinic: _____ Take homes received: _____

Dates to be medicated at Guest facility: _____ to _____ How many days total:_____

Patient Current Dose Level_____mgs. Disket Liquid

Urine Drug Screen requested during guest medication: Yes No

Attendance Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Total take homes allowed per week: _____

Clinic Name:_____

Address_____ City_____ State & Zip_____

Telephone#_____ Fax#_____ Contact_____

Patient Consent For The Release Of Confidential Information:
I understand that my records are protected under Federal and State Regulations pertaining to patient confidentiality, and that information may not be disclosed without my express written consent, unless otherwise provided for within those regulations.I further understand that I may revoke this release at any time except to the extent that action has been taken in accordance withit, and hold Lakeland Centres and its employees harmless from any and all situations arising from the release of information. This release will, unless renewed, expire one-hundred and twenty (120) days from the date of signing. This is a limited disclosure for the purpose as stipulated herein, and as so indicated by the patient from whose records this information has been extracted. This information has been released to you from records whose confidentiality is protected by Federal Regulation 42 CFR part 2 which expressly prohibits you from making any further disclosure without the express written consent of the person to whom it pertains. A general consent for the release of confidential information, medical or otherwise is not sufficient for this purpose.
I request Lakeland Centres to release to the facility indicated above information pertaining to my treatment for guest dosing purposes only.

Patient Name: _____ Signature: _____

Counselor Name: _____ Signature: _____
Date Signed: _____

Lakeland Centres Dispensing Hours
Monday, Tuesday, Wednesday and Friday 6 AM to 9 AM
Thursday and Saturday 7 AM to 9 AM
Sunday 8 AM to 9 AM

DOSE CONFIRMED: YES NO NURSE INITIALS: _____ DATE:_____

PERSON CONFIRMED DOSE WITH: _____ POSITION:_____