

LANCASTER COUNTY DRUG AND ALCOHOL COMMISSION

Request for Funding
Buprenorphine Medication

SUD Treatment Provider Name: _____ Date of First Appointment: ___/___/___

Prescriber's Name: _____ Date of First Appointment: ___/___/___

Referring CRS/Case Manager Name: _____ Referral Date: ___/___/___

ADDITIONAL COMMENTS: