# **Template provider verification and request for reasonable accommodations for patient to self-infuse**

## [insert Date]

## [insert Substance Use Disorder/Mental Health Treatment Facility Name]

## [insert Address of Facility]

## Dear [insert Name of Facility Administrator]:

## [insert full name of patient] is my patient, and has been in my care since [insert date]. I am familiar with their medical condition, [insert name of condition], and the limitations of this disability. The patient is medically stable on [insert pronouns: his/her/their] current treatment regimen and should not require direct medical intervention at your facility. However, the patient’s disability will require [insert pronouns: him/her/them] to self-administer their bleeding disorder medication by [insert IV infusion or injection] [insert schedule of injections or infusions- weekly/ daily, etc] as prescribed.

## [If relevant for infusions, include: The infusion takes approximately five minutes to complete.] [This medication is routinely self-administered [subcutaneously or intravenously.] [*insert patient name*] is fully competent to self-administer their medication.]

## With reasonable accommodations to ensure access to this medication in the stable environment that your facility provides, we are confident that the patient’s bleeding disorder will be sufficiently controlled for admission to [i*nsert facility name*] and enable the patient to fully engage in the treatment provided at your facility without limitation or significant interruption. There are no restrictions for activities except participation in activities that could result in significant physical injury (ex: football, wrestling, hockey, contact martial arts, etc.)

## In order to ensure that [insert patient name] has an equal opportunity to access medically necessary behavioral health care, I am requesting the facility provide the following reasonable accommodation/modification(s):

* Access to prescribed bleeding disorder medication: [insert name of prescribed medication]
* Secure, climate-controlled storage for bleeding disorder medication and associated medical supplies
* Time during the day to receive bleeding disorder medication
* Permission to administer (self-infuse or inject) the bleeding disorder medication or a provider to administer the bleeding disorder medication (staff or external)
* Access to a private space in which to administer the bleeding disorder medication (e.g., a medication room or a private office)
* Presence of a staff member to ensure that only the bleeding disorder medication is infused and the supplies are not misused

Without access to these reasonable accommodations, the patient will be limited due to their disability and associated risk of spontaneous bleeding and bleeding related to routine activities of daily living.

## Thank you for your attention to this request.

## Sincerely,

## [insert provider’s signature and title]

[Insert provider’s contact information]