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| 1. **Pharmacy details**
 |
| Pharmacy name: |       | PBS Approval Number: |       |  |
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| 1. **Report of oral and sublingual CPOP dosing**
 |
|  | Month: |       | Year: |       |  |
|  |
| Drug name1 | Patient forename(s) | Patient surname | Patient DOB | New patient | Patient ceased dosing | Last dose for month(mg) | Number of take-aways | Number of missed doses |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|       |       |       |       | ☐ | ☐ |       |       |       |
|  |
| 1 Drug: Methadone oral liquid (M), Suboxone® film (X), Subutex®  tablet (B) |

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| 1. **Report of dispensed Sublocade and Buvidal injections returned to pharmacy (not administered to client)**
 |
| Name of returned drug2 | Strength(mg) | Patient forename(s) | Patient surname | Patient DOB | Date of dispensing | Date of return |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
|  |
| 2 Drug: Sublocade® injection (D), Buvidal® injection (V) |

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| 1. **Declaration by pharmacist**
 |
| Report certified as complete and correct. |
| Pharmacist name: |       |  |
| Signature: |       | AHPRA Number: |       | Date: |       |  |
| NOTE: This report is to reach the Department of Health **no later** than seven (7) days after the end of the month during which the transactions occurred. Please keep a copy for your records. |