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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 |
|  | |  | |  | | |  | | ☐ | ☐ |  |  |  |
|  | |  | |  | | |  | | ☐ | ☐ |  |  |  |
|  | |  | |  | | |  | | ☐ | ☐ |  |  |  |
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| 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 |
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| 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. | | | | | | | | |