|  |
| --- |
| 1. **Pharmacy details**
 |
| Pharmacy name: |       | PBS Approval Number: |       |  |
|  |

|  |
| --- |
| 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) |

|  |
| --- |
| 1. **Number of patients who received a pharmacist-administered depot buprenorphine product in the month:**
 |
| Buvidal®:  |       |  |  |  |  |  |
| Sublocade®: |       |
|  |  |  |  |  |  |  |

|  |
| --- |
| 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. |