## MONTHLY SUMMARY REPORT AND COVER SHEET

Methadone Syrup — Methadone Liquid - Buprenorphine Subutex <sup>®</sup> - Suboxone <sup>®</sup>							
PHARMACY DETAILS		(AFFIX PHARMACY LABEL HERE)					
Pharmacy Name:							
Address:							
Phone:		Fax:					
REPOR	TING PERIOD						
Month:		Year:					
CLIENT SUMMARY							
Drug* (refer key)	Client first name	Client Surname		Total no. of Doses	Last dose for month (mg)	No. of Take Away Doses	No. missed doses
							1

## PHARMACY AUTHORISATION

M = Methadone Syrup

Pharmacy Name:

\*Drug Key:

Signature:

**ML** = Methadone Liquid – Biodone Forte

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Date:

**NOTE:** This report is to reach the Pharmaceutical Services Branch no later than ten (10) days after the end of the month during which the transactions occurred. **Completed forms** to be faxed to **03 6173 0820** or scanned and emailed to <u>pharmserv@health.tas.gov.au</u>



**B** = Buprenorphine Subutex<sup>®</sup>



**S** = Suboxone<sup>®</sup>