 **MEDICATION ADMINISTRATION CHART**

**Methadone Syrup (5mg/mL)**

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| *Please complete fields below or affix pharmacy label* | *Please complete fields below or affix patient label* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Pharmacy:** |  | **Family Name:** |  |
| **Address:** |  | **Given Name(s):** |  |
| **Phone:** |  | **Patient ID:** |  |
| **Fax:** |  | **Date of Birth** |  | **Gender:**  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Month:** |  | **Year:** |  | **TAD/week:** |  | **Doctor:** |  |

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| Date | Day | Daily Dose (mg) | Daily Vol (mL) | Dose type (R/TAD) | Weekly TAD No. | Pharm Initial | Paid | Notes/Rx Expiry | Time | Client’s Signature |
| 1st |  |  |  |  |  |  |  |  |  |  |
| 2nd |  |  |  |  |  |  |  |  |  |  |
| 3rd |  |  |  |  |  |  |  |  |  |  |
| 4th |  |  |  |  |  |  |  |  |  |  |
| 5th |  |  |  |  |  |  |  |  |  |  |
| 6th |  |  |  |  |  |  |  |  |  |  |
| 7th |  |  |  |  |  |  |  |  |  |  |
| 8th |  |  |  |  |  |  |  |  |  |  |
| 9th |  |  |  |  |  |  |  |  |  |  |
| 10th |  |  |  |  |  |  |  |  |  |  |
| 11th |  |  |  |  |  |  |  |  |  |  |
| 12th |  |  |  |  |  |  |  |  |  |  |
| 13th |  |  |  |  |  |  |  |  |  |  |
| 14th |  |  |  |  |  |  |  |  |  |  |
| 15th |  |  |  |  |  |  |  |  |  |  |
| 16th |  |  |  |  |  |  |  |  |  |  |
| 17th |  |  |  |  |  |  |  |  |  |  |
| 18th |  |  |  |  |  |  |  |  |  |  |
| 19th |  |  |  |  |  |  |  |  |  |  |
| 20th |  |  |  |  |  |  |  |  |  |  |
| 21st |  |  |  |  |  |  |  |  |  |  |
| 22nd |  |  |  |  |  |  |  |  |  |  |
| 23rd |  |  |  |  |  |  |  |  |  |  |
| 24th |  |  |  |  |  |  |  |  |  |  |
| 25th |  |  |  |  |  |  |  |  |  |  |
| 26th |  |  |  |  |  |  |  |  |  |  |
| 27th |  |  |  |  |  |  |  |  |  |  |
| 28th |  |  |  |  |  |  |  |  |  |  |
| 29th |  |  |  |  |  |  |  |  |  |  |
| 30th |  |  |  |  |  |  |  |  |  |  |
| 31st |  |  |  |  |  |  |  |  |  |  |

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| **END OF MONTH SUMMARY (for payment)** | ***Patient status*** *(please tick):* | □ Ongoing patient | □ New patient | □ Ceased dosing |
| Total no. Bupe. Doses: | Last daily dose of month: | Total no. TAD: | Total no. missed doses: | Pharmacist signature: |
|  | ***mg*** |  |  |  |