Tasmanian Government

MEDICATION ADMINISTRATION CHART

Methadone Syrup (5mg/mL)

TASMANIAN HEALTH SERVICE

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:**

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

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										
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14th										
15th										
16th										
17th										
18th										
19th										
20th										
21st										
22nd										
23rd										
24th										
25th										
26th										
27th										
28th										
29th										
30th										
31st										

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: ***mg***	Total no. TAD:	Total no. missed doses:	Pharmacist signature: