

MEDICATION ADMINISTRATION CHART

Methadone Liquid – Biodone Forte (5mg/mL)

Please complete fields below or affix pharmacy label

Please complete fields below or affix patient label

Pharmacy: _____ Address: _____ Phone: _____ Fax: _____	Family Name: _____ Given Name(s): _____ Patient ID: _____ 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
1 st										
2 nd										
3 rd										
4 th										
5 th										
6 th										
7 th										
8 th										
9 th										
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22 nd										
23 rd										
24 th										
25 th										
26 th										
27 th										
28 th										
29 th										
30 th										
31 st										

END OF MONTH SUMMARY (for payment)

Patient status (please tick): Ongoing patient New patient Ceased dosing

Total no. doses:	Last daily dose of month: mg	Total no. TAD:	Total no. missed doses:	Pharmacist signature:
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