Tasmanian Government

MEDICATION ADMINISTRATION CHART
Buprenorphine/Naloxone (SUBOXONE® FILM)

TASMANIAN HEALTH SERVICE

Please complete fields below or affix pharmacy label

Pharmacy:

Address:

Phone:

Fax:

Please complete fields below or affix patient label

Family Name:

Given Name(s):

Client TOPP #:

Date of Birth: **Sex:**

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

Date	Day	Daily Dose (mg)	Tab. Strength 2.0mg/ 0.5mg	Tab. Strength 8.0mg/ 2.0mg	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											

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:

ENTER THIS DATA IN NARCOTIC REGISTER & PRESCRIPTION DETAILS IN DISPENSING COMPUTER. This form is part of the Narcotic Substance Register and must be filed in a binder and retained for a period of two years as per legislation. **Completed forms** to be faxed to **03 6233 3904** or scanned and emailed to pharm.services@dhhs.tas.gov.au