



CONFIDENTIAL REG NO:

**NOTICE OF TERMINATION OF
METHADONE/BUPRENORPHINE/SUBOXONE/SUBUTEX PRESCRIBING**

DETAILS MUST BE COMPLETED **LEGIBLY** TO PREVENT DELAY

TICK DATA AS APPROPRIATE: (PLEASE USE BLOCK LETTERS)

I, DR													
OF:													
POSTCODE													
TELEPHONE NUMBER: (03)	FAX NUMBER: (03)												
NOTIFY THAT THIS PATIENT IS NO LONGER ATTENDING FOR TREATMENT WITH METHADONE./BUPRENORPHINE/SUBOXONE													
PATIENT'S NAME:													
(FAMILY NAME)	(GIVEN NAME(S))												
PATIENT'S ADDRESS:													
(FULL <u>RESIDENTIAL</u> ADDRESS)													
POSTCODE													
NUMBER OF WEEKS ON PROGRAM:													
DATE OF LAST DOSE DISPENSED: / /													
NAME OF PHARMACY WHERE PATIENT HAS BEEN ADMINISTERED METHADONE/BUPRENORPHINE/SUBOXONE DOSES:													
PATIENT:- <table style="width: 100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> LEFT BY MUTUAL AGREEMENT</td> <td><input type="checkbox"/> DECEASED</td> </tr> <tr> <td><input type="checkbox"/> LEFT AGAINST ADVICE OF TREATMENT TEAM</td> <td><input type="checkbox"/> TRANSFER — INTERSTATE</td> </tr> <tr> <td><input type="checkbox"/> REQUESTED TO LEAVE</td> <td><input type="checkbox"/> — INTRASTATE TO DR.....</td> </tr> <tr> <td><input type="checkbox"/> CEASED TO PICK UP METHADONE</td> <td>.....</td> </tr> <tr> <td><input type="checkbox"/> IMPRISONMENT</td> <td><input type="checkbox"/> COMPLETED PROGRAM</td> </tr> <tr> <td><input type="checkbox"/> OTHER, SPECIFY:</td> <td><input type="checkbox"/> HOSPITALISED</td> </tr> </table>		<input type="checkbox"/> LEFT BY MUTUAL AGREEMENT	<input type="checkbox"/> DECEASED	<input type="checkbox"/> LEFT AGAINST ADVICE OF TREATMENT TEAM	<input type="checkbox"/> TRANSFER — INTERSTATE	<input type="checkbox"/> REQUESTED TO LEAVE	<input type="checkbox"/> — INTRASTATE TO DR.....	<input type="checkbox"/> CEASED TO PICK UP METHADONE	<input type="checkbox"/> IMPRISONMENT	<input type="checkbox"/> COMPLETED PROGRAM	<input type="checkbox"/> OTHER, SPECIFY:	<input type="checkbox"/> HOSPITALISED
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SIGNATURE OF MEDICAL PRACTITIONER:	DATE:												
ALL CORRESPONDENCE TO MARKED "CONFIDENTIAL" PHARMACEUTICAL SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES GPO Box 125 HOBART TAS 7001	FOR FURTHER INFORMATION: PHARMACEUTICAL SERVICES TEL: (03) 6233 3906 FAX: (03) 6233 3904												