MEDICATION ADMINISTRATION CHART

Methadone Syrup (5MG/ML)

Tasmanian Government

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)	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										

END OF MONTH SUMMARY (for payment) ***Patient status*** *(please tick):* ☐ Ongoing patient ☐ New patient ☐ Ceased dosing

Total no. Meth. Doses:	Last daily dose of month: ***mL***	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