



CONFIDENTIAL

NOTICE OF TERMINATION OF OPIOID SUBSTANCE USE DISORDER TREATMENT

DETAILS MUST BE COMPLETED LEGIBLY TO PREVENT DELAY
TICK DATA AS APPROPRIATE. PLEASE USE BLOCK LETTERS

I, Dr
of:
(ADDRESS OF MEDICAL PRACTITIONER)
Postcode:
Telephone number: () Fax number: ()
notify that this patient is no longer attending treatment with methadone/buprenorphine/Suboxone®:
PATIENT'S NAME: AKA
Patient's Address:
(Full Residential Address)
Postcode:
Date of Birth: / / Sex: Male Female Other
Number of weeks on program:
Date of last dose dispensed: / /
Name of pharmacy where patient has been administered methadone/buprenorphine/Suboxone® doses:
Left by mutual agreement Deceased
Left against advice of treatment team Transfer - Interstate
Requested to leave - Intrastate: Dr
Ceased to pick up methadone
Imprisonment Completed Program
Other, specify: Hospitalised
Signature of medical practitioner: Date: / /

All correspondence to be marked "Confidential" and sent to:
Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, GPO BOX 125, Hobart TAS 7001

For further information: Tel: (03) 6166 0400, Fax: (03) 6173 0820, Email: pharmserv@health.tas.gov.au