NSW GOVERNMENT Health

Facility:

EXIT FROM METHADONE OR BUPRENORPHINE TREATMENT UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

NSW HEALTH USE ONLY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

This form is available online in PDF format **(http://www.health.nsw.gov.au/pharmaceutical)** and should be filled in electronically using a computer.
If completing the form by hand, please use BLOCK LETTERS and ensure that all details are legible. Exits are generally processed within 2 business days.

Section A: Patient Details

Patient Name:

(given name) *(middle name)* *(family name)*

Patient Residential Address:

Suburb/Town: **Postcode:**

Patient Date of Birth: / / **Sex:** ☐ Male ☐ Female

Section B: Current program details

1. Is the patient exiting a methadone or buprenorphine program?

☐ Methadone
Last dose: mg
Date of last dose including any takeaways issued on current prescription: / /

☐ Buprenorphine
Last dose: mg
Date of last dose including any takeaways issued on current prescription: / /

☐ Buprenorphine injection
Last dose: mg
Date of last dose including any takeaways issued on current prescription: / /

2. Date of entry to latest program: (month/year)

3. Name of last administration (dosing) point:

Suburb/Town:

4. Date commenced at last dosing point: / /

5. Reason for Exiting Treatment: *(tick one box only)*

☐ Patient did not commence treatment
☐ Treatment incomplete (by mutual agreement between prescriber and patient)
☐ Patient successfully completed treatment
☐ Patient ceased to pick up methadone/buprenorphine
☐ Treatment terminated involuntarily
Reason for involuntary termination (e.g. chronic or frequent illegal opioid use, violent or abusive behaviour towards staff, diverting methadone or buprenorphine):

☐ Patient deceased, *Date of death:* / /
☐ Patient transferred to the Justice Health System
☐ Patient transferred to another prescriber, *specify name of new prescriber/clinic:*
☐ Other, *specify:*

Section C: Declaration

This patient has been discharged from methadone/buprenorphine treatment. I declare that I am the current authorised prescriber or I have permission of the current authorised prescriber to discharge the patient.

Name of person discharging patient:

(given name) *(family name)*

Signature of person discharging patient: Print & Sign **Date:** / /

Designation:

Prescriber's Name:

Address:

Fax completed form and supporting documentation to the Pharmaceutical Regulatory Unit: **02 9424 5885**
For enquiries: Tel 02 9424 5921 during business hours.

SMR130052

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

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EXIT FROM METHADONE OR BUPRENORPHINE TREATMENT UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP) SMR130.052