NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

NSW HEALTH USE ONLY

EXIT FROM METHADONE, BUPRENORPHINE OR OTHER OPIOID AGONIST THERAPY (OAT) TREATMENT UNDER THE NSW OPIOID TREATMENT PROGRAM (OTP)

SMR130052

Enquiries: Please direct any enquiries to the Pharmaceutical Regulatory Unit: Tel: **(02) 9424 5921 or** email: MOH-OTP@health.nsw.gov.au
Fax completed form to the Pharmaceutical Regulatory Unit: **(02) 9424 5885** or email to MOH-OTP@health.nsw.gov.au

Section A Prescriber Details

Prescriber Name *(as displayed in AHPRA)*			
	Given Name(s)	Middle Name(s)	Family Name
Name of Practice			
Suburb/Town		Postcode	
Telephone	Fax	Email	
AHPRA Registration No.		PBS Prescriber No.	

Section B Patient Details

Patient Name *(as shown on Medicare card)*			
	Given Name(s)	Middle Name(s)	Family Name
Patient also known as *(if applicable)*			
	Given Name(s)	Middle Name(s)	Family Name
Address			
Suburb/Town		Postcode	
Medicare number *(if applicable)*	_____ Ref no. _____		
DVA number *(if applicable)*	_____		
Date of Birth *(dd/mm/yyyy)*	_____/_____/_____	Sex ☐ M ☐ F ☐ Another term ☐ Not Stated	

Section C Current Program Details

1. Which Opioid Treatment Program is the patient exiting: (tick one box only)
☐ Methadone ☐ Buprenorphine ☐ Other Opioid Agonist Therapy (OAT) Treatment

2. Date of entry to current program: _____/_____ *(month/year)*

3. Date of last dose including any takeaway doses issued on the current prescription: _____/_____/_____

4. Last dose of methadone, buprenorphine, or OAT treatment: _____ **mg**

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

☐ Patient did not commence treatment
☐ Patient successfully completed treatment
☐ Treatment incomplete (by mutual agreement between prescriber and patient)
☐ Patient ceased to pick up methadone/buprenorphine
☐ Change of pharmacotherapy drug
☐ 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 another prescriber, *specify name of new prescriber/clinic:* _____
☐ Patient transferred to the Justice Health System ☐ Other, specify: _____
☐ Unknown

Section D Declaration

☐ **I confirm that the information I have provided in this application is true and complete to the best of my knowledge. This patient has been discharged from an OTP methadone/buprenorphine or OAT treatment.**
☐ **I declare that I am the current authorised prescriber.**
☐ **I have permission from the current authorised prescriber to discharge the patient.**

Name of person discharging the patient: _____
Designation: _____ Signature: _____ Print & Sign _____ Date: _____/_____/_____

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

NH700458A 140823

NO WRITING

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SMR130.052