

# Notification of termination of methadone or buprenorphine program

*Drugs, Poisons and Controlled Substances Act 1981*

(Please print **legibly** in block letters and provide all information. Explanatory notes overleaf)

PRESCRIBER DETAILS	SURNAME (FAMILY NAME)	FIRST NAME
	I, Dr <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	
	ADDRESS <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	
	SUBURB/TOWN <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	POSTCODE <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>
	TELEPHONE <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	FAX <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>

notify that the following patient is no longer attending for treatment on a program incorporating methadone or buprenorphine

Signature of medical practitioner:	Date:
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PATIENT DETAILS	SURNAME (FAMILY NAME)	FIRST NAME
	ADDRESS <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	
	SUBURB/TOWN <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	POSTCODE <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>
	DATE OF BIRTH (DAY/MONTH/YEAR) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	DPU NUMBER (if known) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>
	HAS INTRAVENOUS DRUG USE TAKEN PLACE? YES <input type="checkbox"/> NO <input type="checkbox"/>	

IS THE PATIENT WORKING? YES  NO  DON'T KNOW

PROGRAM DETAILS	DATE OF LAST DOSE CONSUMED:			
	NUMBER OF WEEKS ON PROGRAM: <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	DAY <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	MONTH <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	YEAR <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>
	HIGHEST DOSE CONSUMED (METHADONE): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mg	LAST DOSE CONSUMED (METHADONE): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mg		
	HIGHEST DOSE CONSUMED (BUPRENORPHINE): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mg	LAST DOSE CONSUMED (BUPRENORPHINE): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mg		
	VERIFIED WITH DOSING POINT:	METHADONE YES <input type="checkbox"/>	BUPRENORPHINE NO <input type="checkbox"/>	<input type="checkbox"/>

PHARMACY DETAILS	METHADONE/BUPRENORPHINE DOSES OBTAINED FROM: NAME <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	
	ADDRESS <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	
	SUBURB <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	POSTCODE <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>
	TELEPHONE <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>	FAX <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"></table>

REASON FOR TERMINATION		
<input type="checkbox"/> DID NOT COMMENCE PROGRAM	<input type="checkbox"/> MUTUAL AGREEMENT	<input type="checkbox"/> REQUESTED TO LEAVE BY DOCTOR
<input type="checkbox"/> LEFT AGAINST ADVICE OF TREATMENT TEAM	<input type="checkbox"/> CEASED TO DOSE METHADONE	<input type="checkbox"/> CEASED TO DOSE BUPRENORPHINE
<input type="checkbox"/> TRANSFER – INTERSTATE	<input type="checkbox"/> TRANSFER – INTRASTATE	<input type="checkbox"/> DECEASED
<input type="checkbox"/> IMPRISONMENT	<input type="checkbox"/> RELEASED FROM PRISON	<input type="checkbox"/> HOSPITALISED
<input type="checkbox"/> DISCHARGED FROM HOSPITAL	<input type="checkbox"/> COMPLETED PROGRAM	<input type="checkbox"/> OTHER, SPECIFY _____



## Important notice about privacy

It is a requirement of the *Drugs, Poisons and Controlled Substances Act, 1981* ('the Act') that the information set out on this form is provided to the Department of Human Services (DHS). Failure to provide all the information may delay the processing of your application or the registering of your notification. You are required to inform the patient of the mutual obligations of both medical practitioners and DHS in relation to the collection, storage and use of this information. You are required to generally advise that: The Act requires that this information be provided to DHS:

- to meet statutory notification requirements, and
- for the issuing of permits as required under the legislation.

The Department discloses the information only:

- to a medical practitioner when necessary to facilitate co-ordination of the patient's drug treatment and safe prescribing of drugs, eg when another medical practitioner applies for a permit or is considering prescribing a drug of dependence, or
- to a pharmacist to facilitate payment of pharmacotherapy dosing fees for eligible persons, and
- when otherwise required by law.

The patient has a right to gain access to the information.

Further information about the Department, the *Health Records Act 2001* and other privacy legislation, can be viewed at the Department's web site (<http://www.dhs.vic.gov.au/privacy/>). Access to DHS records can be requested by lodging a Freedom of Information request with the Freedom of Information Unit, Department of Human Services, GPO Box 4057, Melbourne 3001.

### **Fax or post completed application to:**

Manager, Drugs and Poisons Unit  
PO Box 1670N  
MELBOURNE 3001  
Fax: 1300 360 830

### **For further information, please contact:**

Drugs and Poisons Unit  
Telephone: 1300 364 545