Rising Sun Treatment Centre
31 Riverview Rd. W
Eel Ground, NB., E1V-4G2
www.risingsuntreatment.ca

OPIOID REPLACEMENT TREATMENT

Pharmacist – Prescriber Communication

Phone: 506-627-4626
FAX: 506-627-4627

Patient Name: _____ Date Of Birth: DD/MM/YY: _____

To (Prescriber): _____ Health Card: _____ PROV: _____

Fax: _____ Prescription Form Folio Number: _____

From (Pharmacy): _____ Pharmacy Fax: _____

Pharmacist: _____ Pharmacy Telephone: _____

METHADONE CLIENT **OR** **SUBOXONE CLIENT**

For Prescriber's Information and Patient Records

____ This Patient missed their methadone/suboxone dose DD/MM/YY _____

____ This Patient did not take their full daily dose today DD/MM/YY _____

And consumed only _____ mg of a _____ mg prescribed dose

For Prescriber's Signature and return of form to Pharmacy

☐ We require clarity regarding the 'prescribing date' and/or 'start day' for the attached Methadone/suboxone Maintenance Controlled Prescription form. Please indicate the 'actual date' (actual date the prescription was written) and dispensing 'start date' or range.

Prescribing Date: _____

Dispensing Start Date or range: _____

☐ We require clarification and/or a change to the 'Directions for Use' section of the attached Methadone/Suboxone Maintenance Controlled Prescription form.

Description of authorized changes: _____

_____

_____

_____

_____

Prescriber's Name: _____

Band # : | | | | | | | | | | |

Prescriber's Signature: _____

Date: _____

Affix Methadone/Suboxone Maintenance Controlled Prescription form here.

Date of Application (DD/MM/YY): _____