Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Liosta Cóireála Lárnach
Central Treatment List

OPIOID SUBSTITUTION TREATMENT - ENTRY FORM

CLIENT DETAILS
Please complete in BLOCK LETTERS.

INSERT PHOTO

Please ensure the client signs the back of photo & include D.O.B:

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

_____

_____

DATE OF BIRTH: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

CLIENT PH NO: ☐☐☐☐☐☐☐

(OFFICE USE ONLY)

TREATMENT DETAILS

Please check the Central Treatment List prior to commencement of Opioid Substitution Treatment. Tel (01)6488638

COMMENCEMENT DATE: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

DATE DUE TO FINISH: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

(OFFICE USE ONLY)

(TICK WHERE APPROPIATE)

METHADONE: ☐ Buprenorphine/Naloxone: ☐ Buprenorphine: ☐

(Please complete overleaf if the Buprenorphine/Naloxone or Buprenorphine is ticked

CONSENT AGREEMENT

I have been advised and I understand that I have consented to Opioid Substitution Treatment (OST) and my details will be placed on the HSE Central Treatment List (CTL). I understand that my details will be dealt with in a confidential manner and will be kept safe and secure and that my details will be removed from the CTL after five years when I am no longer in treatment.

CLIENT SIGNATURE:
(Please centre signature)

PRESCRIBING CLINIC/DOCTOR NAME	**DISPENSING CLINIC/PHARMACY NAME:**
ADDRESS:	ADDRESS:
TELEPHONE NO:	TELEPHONE NO:
MCRN: ☐☐☐☐☐	**GMS/PCRS:** ☐☐☐☐☐

COMPLETED ORIGINAL FORMS TO BE RETURNED TO;
CENTRAL TREATMENT LIST NATIONAL DRUG TREATMENT CENTRE McCARTHY CENTRE 30/31 PEARSE STREET DUBLIN 2
TEL: (01)6488638 **FAX: (01)6488602**
Please Note: **Treatment card cannot be processed without PATIENT/GUARDIAN SIGNATURE & PHOTOGRAPHS.**

Buprenorphine /Naloxone or Buprenorphine Patient Checklist Treatment
(Relevant to prescribing Buprenorphine/Naloxone or Buprenorphine Only)

Prescriber Details: **(Tick as appropriate)**

Confirmation of Training and participation in evaluation	Yes: ☐	HSE Addiction Service	☐
	No: ☐	Level 2 GP outside Dublin	☐

This is to confirm that the patient is suitable for treatment with Buprenorphine/Naloxone or Buprenorphine per the recommendations*

Yes ☐ No ☐

Dispensing Details:

Daily dispensing available	Yes ☐	No ☐
Pharmacy Joint Care Option	Yes ☐	No ☐

CTL office use Only:

Initial Date Received: (Date Stamped)		**Where Applicable:**
		Co-ordinator:
Logged by:	**Date:**	**Date request sent to Co-ordinator:**
		Date approved by Co-ordinator:
Processed by	**Date:**	**Liaison Pharmacist:**
Date Completed Document Scanned:		**Date request sent to Liaison Pharmacist:**
		Date approved by Liaison Pharmacist:
Checked by:		**Date:**

- **Clinical Recommendations as circulated to prescribers with training materials**