

OPIOID SUBSTITUTION TREATMENT - ENTRY FORM

CLIENT DETAILS

Please complete in BLOCK LETTERS.

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

INSERT PHOTO

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

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 APPROPRIATE)

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: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	GMS/PCRS: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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: <input type="checkbox"/>	HSE Addiction Service	<input type="checkbox"/>
	No: <input type="checkbox"/>	Level 2 GP outside Dublin	<input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>
Pharmacy Joint Care Option	Yes <input type="checkbox"/>	No <input type="checkbox"/>

CTL office use Only:

Initial Date Received:
(Date Stamped)

Logged by:

Date:

Processed by

Date:

Date Completed Document Scanned:

Checked by:

Where Applicable:

Co-ordinator:

Date request sent to Co-ordinator:

Date approved by Co-ordinator:

Liaison Pharmacist:

Date request sent to

Liaison Pharmacist:

Date approved by Liaison Pharmacist:

Date:

- Clinical Recommendations as circulated to prescribers with training materials