CPOP Pharmacotherapy Review Form

(To be completed 6 monthly as a minimum and filed with the patient record)

Date of Completion_____

1. Client Details

Surname_____ Given names_____

Address _____P/code_____

Client contact no. _____

2. Consultation for this review with

- ☐ Pharmacist
- ☐ Counsellor/Case Manager
- ☐ Other _____

- ☐ Missed doses
- ☐ Presenting intoxicated
- ☐ Suspected/established diversion
- ☐ Payment issues
- ☐ Other concerns

3. Current Treatment

☐ Methadone_____mg ☐ Suboxone_____mg ☐ Subutex_____mg ☐ Daily ☐ 2nd daily

a) Current Pharmacy _____

b) Length of time in continuous treatment _____

c) Number of takeaway doses per week _____

d) Prescribed and OTC medications _____

_____

e) Urine screen_____

4. Describe changes in:

a) Physical health and mental wellbeing _____

_____

b) Use of opioid and other drugs (including alcohol) _____

_____

**Use of illicit opioids reported in the past 4 week period? ☐ Yes ☐ No

c) Hepatitis status/immunisation status _____

d) Psychosocial situation _____

_____

e) Legal status _____

_____

f) Contraception/Pregnancy/Breastfeeding _____

_____

Review Summary

Surname _____ **Given names** _____

Problem/Issue	**Goals** (e.g. Reduce symptoms, improve functioning)	**Agreed actions/tasks for review period** (e.g. Medication, referral to psychologist and/or psychologist)
1.		
2.		
3.		
4.		

Proposed Treatment Plan

withdrawal = dose reduction to zero and termination of opioid substitution treatment

a) Client plans to continue maintenance treatment ☐

b) Client plans to commence withdrawal in the next 6 months ☐

c) Client has commenced a planned withdrawal ☐

Referral to _____ ☐

Completed by _____ Designation _____

Date_____

Client signature _____ Date_____

(Provide copy to patient)