Methadone Prescription Fax Form

For Patients on Methadone Maintenance Treatment

Pharmacy Name: Fax:

Patient Name: PHN:

Rx Methadone_____ mg _____Dose in words
p.o. Once Daily (each dose to be individually bottled, labelled and mixed in juice)

Start Date:_____ End Date:_____ Inclusive

Total Doses:_____ Total Observed Doses:_____ Total Take-home doses (carries):_____

Drink observed doses in the pharmacy on days circled:

Mon Tues Wed Thurs Fri Sat Sun

Special instructions:

Hold prescription if two or more consecutive doses are missed and contact prescriber. Notify prescriber if a dose is missed or if there are any concerns about this prescription.

_____ _____ /_____
Physician Signature Print Name License #

_____
Date

Prescriber Certification
This prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are no others. The original prescription has been invalidated or retained so that it cannot be re-issued.
Verification: This certifies the above prescription has been transmitted only to the pharmacy indicated.

Name of Sender: _____ Date Sent: _____