Department of He	Western Australia alth ginal Health Division	Community Program f	Termination opioid substitution treatme for Opioid Pharmacotherapy (CPO
1. Patient details			
First name:	Surr	name:	DOB:
Address:		Suburb:	Postcode:
	onicede to be terminate		

Address:	Suburb:	Postcode:			
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2. Details of treatment episode to be terminated					
☐ Methadone ☐ Suboxone® [☐ Subutex [®] ☐ Buvidal [®]	☐ Sublocade®			
HDWA authorisation number:					
Dose last received (mg): Date of la	ast dose: Pharmacy:				
3. Termination reason					
Please tick one box only:					
1. Mutual agreement	6. Deceased				
2. Left against advice	7. Transfer (intrastate)				
3. Did not commence	8. Transfer (interstate)				
4. Ceased to dose – reason unknown	9. Successfully withdrawn				
5. Involuntary discharge	10. Imprisoned				
11. Other, please specify:					
4. Benefit from treatment					
Overall, do you consider that the patient's quality of life improved during treatment?					
5. Clinical alert					
Should a clinical alert be made for this patient?					
<u> </u>					
6. Prescriber details					
st name: Surname:					
Practice name:					
	Suburb:	Postcode:			
Telephone: Fax:	Email:				
7. Prescriber declaration					
Signature:	Date:				

Facsimile: 9222 2463 Email: mprb@health.wa.gov.au

Enquiries: Tel: 9222 6812 D00010.1