----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.
1234 567 890

PRESCRIBING DATE
01 DAY | 07 MONTH | 21 YEAR

PATIENT NAME
FIRST (GIVEN): Generic
MIDDLE / INITIAL: A
LAST (SURNAME): Name

PATIENT ADDRESS
STREET: 123 Main Street
CITY: Victoria
PROVINCE: BC

DATE OF BIRTH
03 DAY | 09 MONTH | 88 YEAR

Rx: DRUG NAME AND STRENGTH
ONLY ONE DRUG PER FORM
VOID IF ALTERED

Methadone 10mg/mL

QUANTITY (IN UNITS)
150mg (NUMERIC)
One hundred and fifty milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: 01 DAY | 07 MONTH | 21 YEAR
END DATE: 05 DAY | 07 MONTH | 21 YEAR

TOTAL DAILY DOSE
30 NUMERIC
Thirty ALPHA
mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
7 NUMERIC
Seven ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 30mg once daily
Daily witnessed ingestion

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898
PRESCRIBER ID

0000000001
FOLIO

PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE

SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES
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