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

PERSONAL HEALTH NO. 1234 567 890

PRESCRIBING DATE 15 (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)

2,240mg (NUMERIC) — Two thousand two hundred and forty milligrams (ALPHA)

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

START DATE: 15 (DAY) 07 (MONTH) 21 (YEAR) **END DATE:** 11 (DAY) 08 (MONTH) 21 (YEAR)

TOTAL DAILY DOSE

80 (NUMERIC) — Eighty (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 80mg 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

0000000003
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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