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

PERSONAL HEALTH NO. 1234 567 890

PRESCRIBING DATE 12 (DAY) 08 (MONTH) 21 (YEAR)

PATIENT NAME

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

PATIENT ADDRESS

STREET: 123 Main Street

CITY	PROVINCE
Victoria	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)

NUMERIC	ALPHA
2,800mg	Two thousand eight hundred milligrams

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

START DATE: 12 (DAY) 08 (MONTH) 21 (YEAR) **END DATE:** 08 (DAY) 09 (MONTH) 21 (YEAR)

TOTAL DAILY DOSE		NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION	
NUMERIC	ALPHA	NUMERIC	ALPHA
100	One hundred mg/day	5	Five

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 100mg once daily
Daily witnessed ingestion Monday–Friday
Carry doses Saturday and Sunday, dispensed on Friday

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

0000000004
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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