Government of **Western Australia**
Department of **Health**
Public and Aboriginal Health Division

Pharmacy monthly report
Community Program for Opioid Pharmacotherapy (CPOP)

1. Pharmacy details

Pharmacy name: _____ PBS Approval Number: _____

2. Report of oral and sublingual CPOP dosing

Month: _____ Year: _____

Drug name[1]	Patient forename(s)	Patient surname	Patient DOB	New patient	Patient ceased dosing	Last dose for month (mg)	Number of take-aways	Number of missed doses
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[1] Drug: Methadone oral liquid (M), Suboxone® film (X), Subutex® tablet (B)

3. Number of patients who received a pharmacist-administered depot buprenorphine product in the month:

Buvidal®: _____

Sublocade®: _____

4. Declaration by pharmacist

Report certified as complete and correct.

Pharmacist name: _____

Signature: _____ AHPRA Number: _____ Date: _____

NOTE: This report is to reach the Department of Health **no later** than seven (7) days after the end of the month during which the transactions occurred. Please keep a copy for your records.