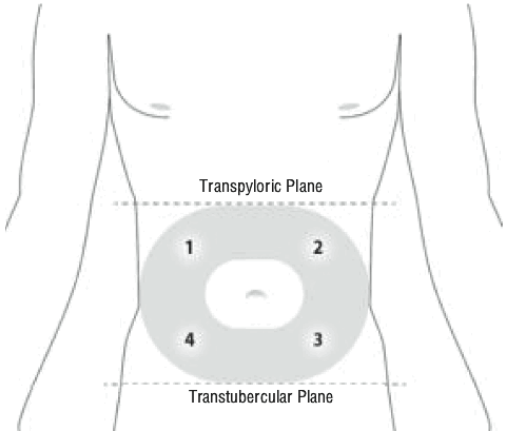
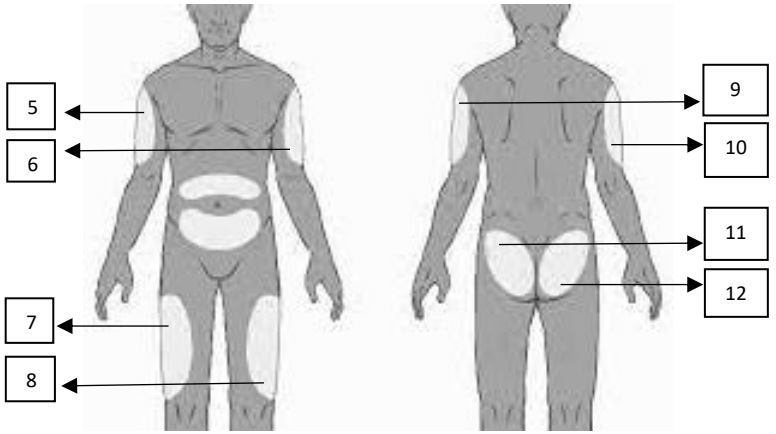
Western Australian Community Program for Opioid Pharmacotherapy (CPOP)

Depot Buprenorphine Administration – Pharmacist Record	**Client Name:** **DOB:** **Prescriber:**

Date	Formulation and dose administered			Injection site (1 to 12) *sites should be rotated	Depot		Administered by		Client sign	Next review appt scheduled	Notes
	Buvidal		Sublocade		Batch No.	Expiry date	Name	Sign			
	Weekly	Monthly									



Sublocade injection sites



Buvidal injection sites

Consent for Pharmacist Administration of prescribed Depot Buprenorphine

I (Name) _____consent to pharmacist administration of depot buprenorphine as prescribed by my prescriber. I understand that the pharmacist providing this treatment has undertaken the required training and is approved within the CPOP program to provide this service to patients under the direction of my prescriber.

I have signed a consent to receive opioid substitution treatment within the CPOP and my prescriber has explained the treatments available to me.

I understand that my prescriber is responsible for reviewing my treatment plan and progress, which should occur within the week preceding my dose administration whilst receiving depot buprenorphine. The pharmacist may choose to refer me back to the prescriber for further review prior to administering my dose should there be any concerns regarding my presentation, timing, or the treatment to be administered.

I understand that it is my responsibility to ensure that I schedule an appointment with my prescriber one week before my next dose becomes due.

Patient signature _____ Date_____ Pharmacist signature_____ Date_____