Opioid Maintenance Treatment Collection Form

ACT Government | ACT Health

....

Client's Name *DOB*

.....

Client's Address

Medication Name:
Dose:
Number of doses collected:
Today's date:

Agent:

I confirm that the details above are correct and that I will deliver these medications to the client at their address today.
I will not leave the doses unattended at any time and will follow the appropriate procedure when delivering the doses, including observing collection of the dose by the client from a safe distance.

....

Agent Name *Agent Signature*

Health professional:

I confirm the details provided above are correct, and that I have confirmed the identity of the agent.

....

Pharmacist or RN name *Pharmacist or RN Signature*

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Accessibility

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.

If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50.

For further accessibility information, visit: www.health.act.gov.au/accessibility

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