<b>OPIOID SUBSTITUTION TREATMENT - ENTRY FORM</b>		
CLIENT DETAILS		
Please complete in BLOCK LETTERS.	INSERT PHOTO	
SURNAME:	Please ensure the	
FIRST NAME:	client signs the back of photo & include	
ADDRESS:	D.O.B:	
	CLIENT PH NO: OFFICE USE ONLY)	
TREATMENT DETAILS		
Please check the Central Treatment List prior to comme	encement of Opioid Substitution Treatment. Tel (01)6488638	
	DAY MONTH YEAR DATE DUE TO FINISH:	
	ine/Naloxone: Buprenorphine: overleaf if the Buprenorphine/Naloxone or Buprenorphine is ticked	
I have been advised and I understand that I have on my details will be placed on the HSE Central Treatmeters	AGREEMENT consented to Opioid Substitution Treatment (OST) and nent List (CTL). I understand that my details will be safe and secure and that my details will be removed in treatment.	
CLIENT SIGNATURE: (Please centre signature)		
PRESCRIBING CLINIC/DOCTOR NAME	DISPENSING CLINIC/PHARMACY NAME:	
ADDRESS:	ADDRESS:	
	GMS/PCRS:	
HSE Email/Healthmail address:	HSE Email/Healthmail address:	
COMPLETED ORIGINALFORMS TO BE RETURNED TO;CENTRAL TREATMENT LIST NATIONAL DRUG TREATMENT CENTRE MTEL: (01)6488638or by healthmail: centraltreatmentlist.gpPlease Note:Treatment card cannot be processed without		

Buprenorphine /Naloxone or Buprenorphine Patient Checklist Treatment (Relevant to prescribing Buprenorphine/Naloxone or Buprenorphine Only)		
Prescriber Details: (Tick as ap	propriate)	
Confirmation of Training and participation in evaluation	Yes: No:	HSE Addiction Service
This is to confirm that the patient is suitable for treatment with Buprenorphine/Naloxone or Buprenorphine per the recommendations*         Or Buprenorphine per the recommendations*         Yes       No		
Dispensing Details:		
Daily dispensing available	Yes	No
Pharmacy Joint Care Option	Yes	No
CTL office use Only:		
Initial Date Received: (Date Stamped)		<u>Where Applicable</u> :
(Date Stamped)		Co-ordinator:
	Date:	Co-ordinator: Date request sent to Co-ordinator:
(Date Stamped) Logged by:		Co-ordinator: Date request sent to Co-ordinator: Date approved by Co-ordinator:
(Date Stamped)	Date: Date:	Co-ordinator: Date request sent to Co-ordinator:
(Date Stamped) Logged by:	Date:	Co-ordinator: Date request sent to Co-ordinator: Date approved by Co-ordinator:
(Date Stamped) Logged by: Processed by	Date:	Co-ordinator: Date request sent to Co-ordinator: Date approved by Co-ordinator: Liaison Pharmacist: Date request sent to Liaison Pharmacist: Date approved by Liaison