Community Pharmacy Claim Form
Daily Individual Patient Supervised Consumption Form

Pharmacy Details ____

Client Details ____

Month ________________ Year ________________

Date	Methadone x	Subutex x	Amount Given	Initials of Pharmacist	Comments
1st					
2nd					
3rd					
4th					
5th					
6th					
7th					
8th					
9th					
10th					
11th					
12th					
13th					
14th					
15th					
16th					
17th					
18th					
19th					
20th					
21st					
22nd					
23rd					
24th					
25th					
26th					
27th					
28th					
29th					
30th					
31st					
Please complete Total >					

Total Number of Supervised Methadone/Subutex doses ________________

Total amount of days supervised ___________

Total days NOT Supervised (Do not include days you are closed) ___________

Pharmacist Signature ____

Print Name ________________________ Date_____________

Please return this form at the end of each month with Monthly payment sheet