

ED Methadone Rx

Emergency Department: _____

Address: _____

Phone: _____

PATIENT DEMOGRAPHIC INFORMATION	
Name	
Health Care #	
DOB	
Phone Number	
Patient Address	
Primary Care Provider	

Date: _____

Methadone 10mg/ml oral Solution

Dose: _____mg

Take _____mg by mouth once daily X _____day(s).

All doses are to be observed in the pharmacy.

Rx Valid _____(dd/mm/yy) to _____(dd/mm/yy) inclusive.

Last dose administered at Hospital Emergency Department: _____ on _____(dd/mm/yy).

MD/NP Signature _____ CPSO/CNO# _____