DEPARTMENT OF
HEALTH

BUPRENORPHINE INJECTION DEPOT LOG

THIS IS NOT AN ADMINISTRATION FORM – refer to AOD Dosing Directive and Script for prescription

Clinician to print patient label and check accuracy

Principal Name
Other Name(s)
DOB
HRN
Sex

Patient Label

Address to be documented if patient details wri en

Month and Year: ____________________________/20___

SITE GIVEN LEGEND							
LA: Le Abdomen	**RA:** Right Abdomen	**LB:** Left Buttock	**RB:** Right Buttock	**LT:** Left Thigh	**RT:** Right Thigh	**LUA:** Left Upper Arm	**RUA:** Right Upper Arm

Regime: ☐ Buvidal Weekly ☐ Buvidal Monthly ☐ Sublocade

Date	Prescribed Dose (mg)	Frequency (Tick box)		Batch number	Expiry date	Injection Site	Clinician Signature/s		Patient Signature	Directive Date	Date of next dose	Comments
		1/52	1/12									

Top-up injection doses (if required)

Date	Prescribed Dose (mg)	Frequency (Tick box)		Batch number	Expiry date	Injection Site	Clinician Signature/s		Patient Signature	Directive Date	Date of next dose	Comments
		1/52	1/12									

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