(PERF)

----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.

PRESCRIBING DATE DAY MONTH YEAR

PATIENT NAME FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS STREET CITY PROVINCE

DATE OF BIRTH DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM

VOID IF ALTERED

QUANTITY (IN UNITS) NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE NUMERIC ALPHA /day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
DR. THE-QUICK-BROWN-FOX-JUMPED-OVER-THE
123SUPERCALAFRAGILISTICEX
IFYOUSAYITFASTENOUGHITSOU
KUALALAMPURDUBAIPARISDUBL BC
ABC1234567 234-456-7890

11551 91
PRESCRIBER ID

000001
FOLIO

PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE

SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES
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