



Drug Treatment Programme

THE MANAGEMENT OF OPIATE USERS IN PRIMARY CARE

Dr. Ide Delargy

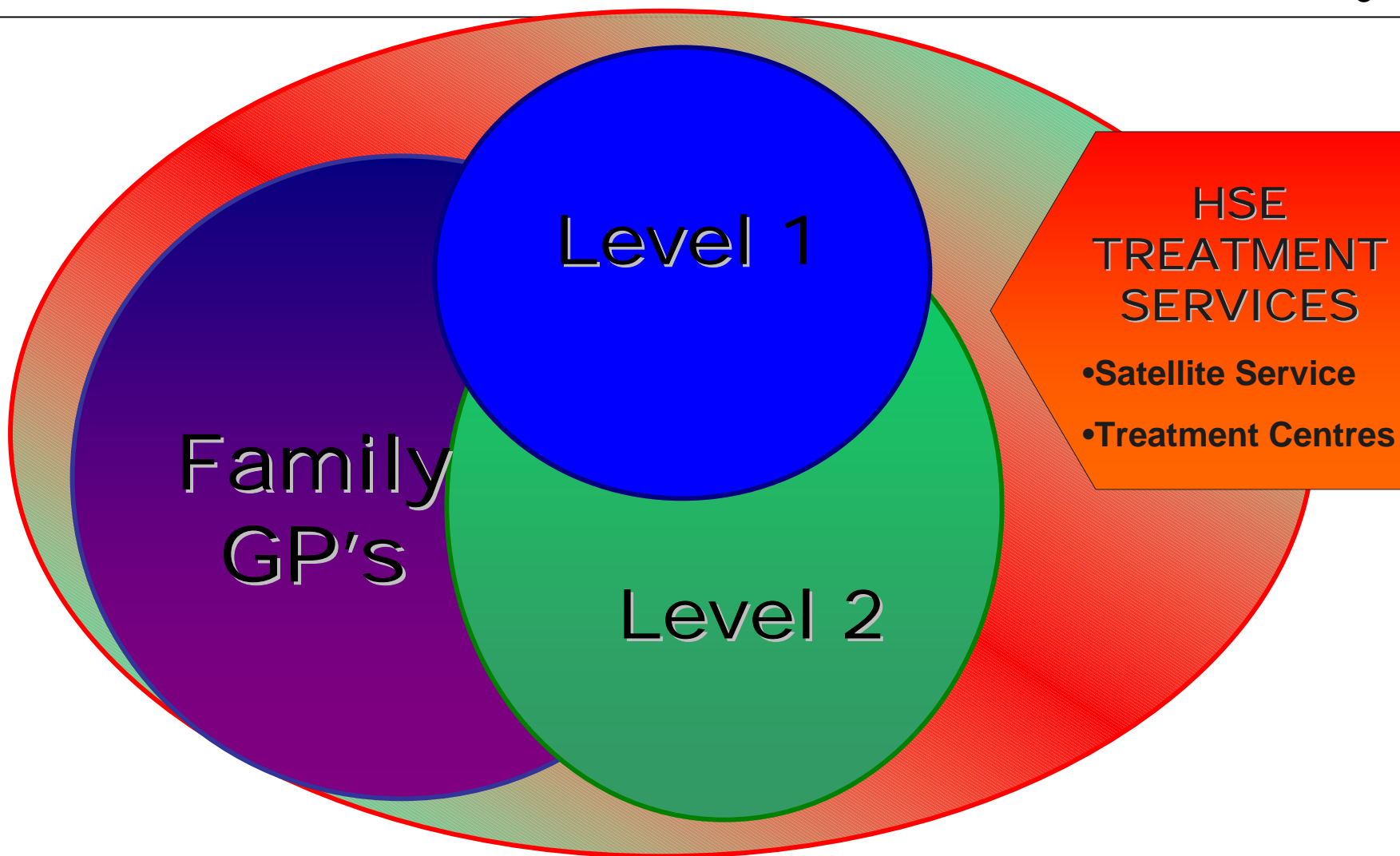
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What are we trying to achieve ?...

aiming for harm reduction NOT cure

- -public health- reduces HIV transmission
- -improves individual health
- -reduces drug related deaths
- -improves social functioning
- -reduces criminality



Methadone Treatment Protocol

National Programme

G.P. / Community Pharmacy based

Central Treatment list

Methadone specific script

Training for G.P.s – Levels 1 & 2

Stable patients only

Maximum number: 15

What does a Level 1 GP do?

- Manage your own stabilised patient
- Patients with history violence or an active addiction will not be referred
- Weekly monitoring: urine sampling
- Weekly methadone script
- Once weekly supervision of dispensing

What does a Level 1 GP do?

- Support from local HSE service or National GP Co-ordinator
- Liase with community pharmacist
- Re-referral if patient destabilises
- Contract for services
- Regular training updates and audit

METHADONE PRESCRIPTION FORM

PHARMACY SEQUENCE NO.

SERIAL NO.

233595

PATIENT DETAILS

SURNAME

BLOGGS

FIRST NAME

JOE

ADDRESS

2-4 LINCOLN PLACE
DUBLIN 2.

PATIENT'S AGE IF UNDER 12 YEARS

TREATMENT CARD NO.

P.H. 1, 2, 3, 4, 5

PRESCRIPTION DETAILS

DRUG NAME, FORM AND STRENGTH

DATE PRESCRIBED

2, 2, 22

METHADONE

FROM	TO	DOSAGE (mls PER DAY)	NO. OF DAYS AT DOSE	TOTAL (mls) (IN FIGURES)
<u>2, 2, 22</u>	<u>8, 2, 22</u>	<u>60</u>	<u>7</u>	<u>420</u>

TOTAL (mls) IN WORDS

(NOT MORE THAN 7 DAYS SUPPLY SHOULD BE PRESCRIBED EXCEPT IN EXCEPTIONAL CIRCUMSTANCES)

Four Hundred and Twenty

DOCTOR'S SIGNATURE

John Delaney

DOCTOR'S NO.

610, 360

DOCTOR'S NAME, ADDRESS AND TELEPHONE NUMBER OR STAMP

DR. DELANEY
2-4 LINCOLN PLACE
DUBLIN 2.

INSTALMENT INSTRUCTIONS

INTERVALS

DAILY

DAILY (WITH DOUBLE ON SAT.)

OTHER (TICK)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MON	TUES	WED	THURS	FRI	SAT	SUN

SUPERVISION INSTRUCTIONS

SUPERVISED

MONDAY TO SATURDAY

EVERYDAY

OTHER (TICK)

*YES NO

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MON	TUES	WED	THURS	FRI	SAT	SUN

***ONLY WITH PRIOR AGREEMENT OF PHARMACIST**

PHARMACY SECTION

PHARMACY GMS NO.

NO. OF

PHARMACY NAME & ADDRESS STAMP

DRUG CODE

QUANTITY (mls)

NO. OF INSTALMENTS

SUPERVISED DAYS

YES NO

DATE DISPENSED

QUANTITY (mls)

PHARMACIST'S INITIALS

DATE DISPENSED	QUANTITY (mls)	PHARMACIST'S INITIALS

I VERIFY THAT I HAVE DISPENSED THE ITEM(S) SPECIFIED HEREON

PHARMACIST'S SIGNATURE _____

I VERIFY THAT I HAVE RECEIVED THE ITEM(S) SPECIFIED HEREON

SIGNATURE _____

OF PATIENT OR PATIENT'S REPRESENTATIVE

TO BE COMPLETED IN THE CASE OF NON-OPIATE DEPENDENT PERSON

NAME AND ADDRESS OF INITIATING CONSULTANT

HOSPITAL _____

HEALTH SERVICES SCHEME

GMS EEA OTHER

MEDICAL CARD NO.



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