

MEDICATION TRACKER

MOUD PARTICIPANT INFORMATION

Participant Number 21978

First Name DINEO SEHODIE Last Name MOOIMAKWANE

Address 2416 70th AVE W APT 86

City UNIVERSITY PLACE State WA

Zip Code 98466 Phone 253 227 3025

ALLERGIES

1 HOUSE DUST 2

MOUD TREATMENT PLAN

Mark x	Medication	Dosage	Frequency	Form	Route	Instructions
	Buprenorphine		time(s)			
	Naltrexone		time(s)			
X	Methadone	50mg	1 time(s) DAILY	CAPSULE	ORAL	Take 1 pill daily
	Other:		time(s)			

MEDICATION INTAKE PROGRESS

MEDICATION NAME METHADONE MONTH: JULY YEAR 2024

Date	Medication taken today?		Dosage	Frequency		Form (Tablet, Capsule, Liquid, Spray)	Route (oral, IV)	
	Yes	No		(How many times a day)				
1	X		50mg	1	time(s)	DAILY	TABLET CAPSULE	ORAL
2	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
3	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
4	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
5		X			time(s)			
6		X			time(s)			
7	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
8	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
9	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
10	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
11	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
12	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
13	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
14	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
15	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
16	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
17	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
18	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
19	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
20	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
21	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
22	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
23	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
24	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
25	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
26	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
27	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
28	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
29	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
30	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL
31	X		50mg	1	time(s)	DAILY	CAPSULE	ORAL

Instructions

Medication Name: Write as per Treatment Plan
 Month: e.g. July
 Year: e.g. 2024
 Medication taken? Mark with X to select YES or NO
 Dosage: as per treatment plan
 Frequency: e.g. 1 time Daily, 3 times Daily
 Form: e.g. tablet, capsule, liquid, spray, injection
 Route: e.g. oral, intramuscular-IM

Details of MOUD Program

Name of OTP Program

LAKEWOOD

Address

2028 3rd LAKE

Phone

253 227 3025

Doctor/Clinician Name

DR WORRI WELER

Details of your Pharmacy

Name

WALGREENS

Phone

253 227 3025