



**CONFIDENTIAL**  
**Department of Health and Human Services**

Section 59 E Poisons Act 1971  
 Regulation 19 Poisons Regulations 2008

**APPLICATION FOR AUTHORITY TO PRESCRIBE AMPHETAMINE OR RELATED SUBSTANCES  
 (DEXAMPHETAMINE OR METHYLPHENIDATE)  
 FOR CHILDREN AND ADOLESCENTS (UNDER 18 YEARS)**

DETAILS MUST BE COMPLETED LEGIBLY TO PREVENT DELAY TICK DATA AS APPROPRIATE PLEASE USE BLOCK LETTERS

I,	
of:	
<small>(ADDRESS OF MEDICAL PRACTITIONER)</small>	
Postcode	
Telephone number: <b>(03)</b>	Fax number: <b>(03)</b>
apply for authority to prescribe for:	
PATIENT'S NAME:	
<small>(Given)</small>	
<small>(Family)</small>	
Patient's Address .....	Postcode: .....
<small>(Full <b>Residential</b> Address)</small>	
Date of Birth:     /     /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Carer 1.....D.O.B.....	Carer 2.....D.O.B.....
relationship to child .....	relationship to child.....
Drug: <input type="checkbox"/> Dexamphetamine	<input type="checkbox"/> Methylphenidate
Diagnosis:	
<input type="checkbox"/> (314.01)	Attention Deficit/Hyperactivity disorder, combined or predominantly hyperactive impulse type
<input type="checkbox"/> (314.00)	Attention Deficit/Hyperactivity disorder, predominantly inattentive type
<input type="checkbox"/> Other -	Please specify.....
Comments regarding application, including previous treatments.	
.....	
I have reason to believe that there may be concerns with misuse of schedule 8 medications based on the following:	
<input type="checkbox"/>	This patient has a history of drug seeking behaviour
<input type="checkbox"/>	The carers/parents have a history of drug seeking behaviour
<input type="checkbox"/>	The carers/parents receive an opioid pharmacotherapy for drug dependence
<b>Please Note:</b> Where there is concern in relation to misuse and diversion of drugs of dependence by a child parents or carer conditions on supply of this medication may be applied.	
<b>NOTE:</b>	<b><u>CHILDREN UNDER 3 YEARS OF AGE REQUIRE A SECOND OPINION.</u></b>
<b>DECLARATION:</b>	I certify that the patient satisfies the diagnostic criteria of the Diagnostic & Statistical Manual of Mental Disorders (DSM-IV) for AD/HD.
Signature of medical practitioner:	Date:     /     /     .
<b>Applications to:</b> Pharmaceutical Services PO Box 125 HOBART TAS 7001	<b>Enquiries:</b> Ph 03 62332064   Fax 03 62 333904 Email: pharm.services@dhhs.tas.gov.au