



Section 59 E Poisons Act 1971
Regulation 19 Poisons Regulations 2008
**APPLICATION FOR AUTHORITY TO PRESCRIBE AMPHETAMINE OR RELATED SUBSTANCES
(DEXAMPHETAMINE OR METHYLPHENIDATE)
FOR ADULTS (OVER 18 YEARS)**

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

I, Dr			
of:			
<small>(ADDRESS OF MEDICAL PRACTITIONER)</small>			
Postcode			
Telephone number		Fax number:	
apply for authority to prescribe for:			
PATIENT'S NAME:			
Patient's Address			
<small>(Full Residential Address)</small>			
		Postcode:	
Date of Birth:	/ /	Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Usual Occupation:		Working:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug:	Dexamphetamine		Methylphenidate
Dose mg/day	Period.....	weeks*/months*(*Delete one)
Nominated co-prescriber:.....			
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"/>	(347)	Narcolepsy to be accompanied by a sleep study report.	
<input type="checkbox"/>	Other -	Please specify.....	
NOTE: Initial authority for treatment of AD/HD is restricted to psychiatrists and neurologists. Symptoms of AD/HD must have been present since early childhood.			
Patient has been previously treated by:			
Other medications being concurrently prescribed:			
Patient has received opioid pharmacotherapy as part of any opioid pharmacotherapy program YES / NO (circle)			
And I have reason to believe that this person in the last 10 years			
<input type="checkbox"/>	Has a history of drug seeking behaviour		
<input type="checkbox"/>	Has exhibited or Is exhibiting drug seeking behaviour		
<input type="checkbox"/>	Has used a notifiable or schedule 8 substances contrary to prescribing instructions and route of administration. (e.g. escalation of dose, injecting medication)		
<input type="checkbox"/>	that none of the above is applies to this patient		
Note: A second psychiatric opinion is required if any of the above apply and the reverse of this form to completed by 2 nd psychiatrist			
DECLARATION: I certify that the patient satisfies the diagnostic criteria of the Diagnostic & Statistical Manual of Mental Disorders (DSM-IV) For AD/HD or Narcolepsy.			
Signature of medical practitioner:			Date: / / .
All Correspondance to be sent to: Pharmaceutical Services Branch Department of Health and Human Services GPO Box 125 HOBART TAS 7001		Enquiries Ph: 03 62 33 2064 Fax: 03 62 33 3904 email: pharm.services@dhhs.tas.gov.au	

HISTORY OF DRUG ABUSE

SECOND PSYCHIATRIC OPINION

I, Dr

of

Phone: (.....).....

support*/do not support* the use of psychostimulents in the treatment of

(PATIENT'S NAME)

.....

.....

.....

Signature of Medical Practitioner.....

Date...../...../.....