PT No: .....

CONFIDENTIAL

Tasmanian Government

NOTICE OF DRUG DEPENDENCY AND APPLICATION FOR AN AUTHORITY TO ADMINISTER, PRESCRIBE OR SUPPLY OPIOID SUBSTANCE USE DISORDER TREATMENT

DETAILS MUST BE COMPLETED ***LEGIBLY*** TO PREVENT DELAY
TICK DATA AS APPROPRIATE. PLEASE USE BLOCK LETTERS
ATTACH CERTIFIED PHOTO TO APPLICATION

I, Dr

of: Postcode:
(ADDRESS OF MEDICAL PRACTITIONER)

Telephone number: ( ) Fax number: ( )

certify that this patient is suffering from drug dependency and, in my opinion, buprenorphine/methadone is required in support of treatment and buprenorphine/methadone will be administered in accordance with the relevant clinical guidelines.

Please indicate whether treatment:

- ☐ Maintenance: Methadone
- ☐ Maintenance: Buprenorphine
- ☐ Maintenance: Buprenorphine/Naloxone
- ☐ Withdrawal: Buprenorphine only

PATIENT'S NAME: **AKA**

Patient's Address:
(Full **Residential** Address)

Postcode:

Date of Birth: / / Sex: ☐ Male ☐ Female ☐ Other

Usual Occupation: Working: ☐ Yes ☐ No

Mother's Maiden Name:

☐ I have checked DORA regarding this patient within the last seven days

Anticipated Date of First Dose**:** Anticipated Date of Last Dose:

Name of dosing pharmacy: .....

Name of Treatment Facility for buprenorphine withdrawal: ☐ In Patient ☐ Out Patient

Name of former prescriber:
(leave blank if there is no former prescriber)

If prior buprenorphine/methadone maintenance:

- Age when first registered:
- Date of last dose of buprenorphine/methadone:

Grounds for drug dependency: ☐ Iatrogenic ☐ Illicit **IVDU:** ☐ Yes ☐ No

Drug(s) involved: (please circle) Other (please specify): .....

alprazolam	Anamorph®	Dilaudid tablets/injections®	Durogesic®	Endone®
flunitrazepam	heroin	Kapanol®	methadone syrup	Momex®
morphine injections	MS Contin®	MS Mono®	Norspan®	Ordine®
OxyContin®	OxyNorm liquid/capsules®	pethidine	Physeptone®	Sevredol®
Subutex/Suboxone®	Temgesic®			

Signature of medical practitioner: Date: / /

All correspondence to be marked "Confidential" and sent to:
Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, GPO BOX 125, Hobart TAS 7001
For further information: Tel: (03) 6166 0400, Fax: (03) 6173 0820, Email: pharmserv@health.tas.gov.au