CONFIDENTIAL

APPLICATION FOR AUTHORITY TO PRESCRIBE AMFETAMINE OR RELATED SUBSTANCES (DEXAMFETAMINE, LISDEXAMFETAMINE OR METHYLPHENIDATE) FOR CHILDREN AND ADOLESCENTS (UNDER 18 YEARS)

Section 59E *Poisons Act 1971*
Regulation 24 *Poisons Regulations 2018*

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

I, Dr

of:
(ADDRESS OF MEDICAL PRACTITIONER)
Postcode:

Telephone number: ( ) Fax number: ( )

apply for authority to prescribe for:

PATIENT'S NAME: **AKA**

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

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

Usual Occupation: Working: ☐ Yes ☐ No

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

Carer 1.. DOB .... Carer 2 .... DOB ....

Relationship to child .... Relationship to child ....

Drug: ☐ Dexamfetamine ☐ Lisdexamfetamine ☐ Methylphenidate

Nominated co-prescriber: ....

Diagnosis:

☐ (314.01) Attention Deficit/Hyperactivity disorder, combined or predominantly hyperactive impulse type

☐ (314.00) Attention Deficit/Hyperactivity disorder, predominantly inattentive type

☐ Other -
Please specify..

Comments regarding application, including previous treatments:

....
....
....

I have reason to believe that there is a history of drug seeking behaviour involving

☐ This patient has a history of drug seeking behaviour

☐ The carers/parents have a history of drug seeking behaviour

☐ The carers/parents receive an opioid pharmacotherapy for drug dependence

Please Note: Where there is concern in relation to misuse and diversion of drugs of dependence by a child's parents or carer, conditions on supply of this medication may be applied.

NOTE: ***CHILDREN UNDER 3 YEARS OF AGE REQUIRE A SECOND OPINION.***

DECLARATION: I certify that the patient satisfies the diagnostic criteria of the Diagnostic & Statistical Manual of Mental Disorders (DSM-V) For ADHD

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