

## APPLICATION FOR AUTHORITY TO PRESCRIBE A RESTRICTED S8 PSYCHOSTIMULANT MEDICATION

Poisons Control ~ Fax: 8922 7200 Phone: 8922 7341

### PATIENT DETAILS (please print clearly)

Surname:..... Given names:.....  
Pseudonym:..... Date of birth: ...../...../..... Sex:  M  F  
Name of parent or guardian (if child under 18) .....  
Address:.....  
.....  
Medicare Card No:..... Health Care Card No:.....

### MEDICATION

Dexamphetamine Dose:.....  
 Methylphenidate Dose:.....

### DIAGNOSIS

Narcolepsy  Attention Deficit Disorder  Adult Attention Deficit Disorder

### PRESCRIBER

Prescriber name:..... Prescriber No.....  
Address.....  
Phone number..... Fax number.....  
Category  Paediatrician  Neurologist  Psychiatrist  Other.....  
 Physician  GP  Registrar  
Prescribers signature..... Date ...../...../.....

**If prescribing Medical Officer is not a paediatrician/neurologist/psychiatrist/physician or registrar in training,  
or if second opinion needed for clients under 4 years:**

### SPECIALIST INITIATING PRESCRIPTION OR REVIEWING PATIENT

Name:..... Address.....  
Phone number..... Fax number..... Date client last seen...../...../.....  
Category  Paediatrician  Neurologist  Psychiatrist  Other.....  
 Physician  GP  Registrar  
Interstate specialist? .....Y / N  
Prescriber must personally verify decision to prescribe with interstate specialist. Done?.....Y / N