Government of **Western Australia**
Department of **Health**

Poisons Regulations 1965

NOTIFICATION OF TREATMENT USING STIMULANT MEDICATION

PATIENT DETAILS (*PRINT IN BLOCK LETTERS)*

First Name		Surname	
Full Address			Postcode
Medicare No	Weight (kg) *(Children only)*	DOB	Male ☐ Female ☐

Please tick ☑

☐ Notification of Treatment within the criteria set out in the Stimulant Prescribing Code

☐ Re-notification by same authorised stimulant prescriber (please circle change since last notification)

Dose ***Drug*** ***Drug form*** ***Nominated Co-prescriber*** ***Patient details***

☐ Termination of treatment with stimulants: Reason _____

☐ Application for authorisation to prescribe outside the criteria set out in the Stimulant Prescribing Code (please circle reason)

Age ***High Dose*** ***Hx bipolar*** ***Hx Psychosis*** ***Substance Abuse***

NOTE: *Prior written authorisation from the CEO of Health is required to prescribe outside the criteria set out in the Code. A comprehensive clinical report and information according to the relevant Application Checklist is to accompany all applications.*

Primary condition being treated:

☐ ADHD* →

☐ Brain damage

☐ Narcolepsy

☐ Depression

If ADHD is the primary diagnosis:

Which Diagnostic Criterion was used? ☐ ICD-10 ☐ DSM-IV

Is the patient on other psychotropic drugs? ☐ Yes ☐ No

If yes, please specify:

☐ Antidepressants ☐ Mood stabilising agents
☐ Antipsychotics ☐ Other psychotropics
☐ Anxiolytics

Stimulant(s) to be prescribed and total daily dose:

☐ Dexamphetamine ..... mg/day

☐ Dexamphetamine (compounded) ..... mg/day

☐ Methylphenidate ..... mg/day

☐ Methylphenidate Long Acting ..... mg/day

Is the patient being treated at a registered public clinic? ☐ Yes ☐ No

If Yes, Name of Clinic: .....

☐ PATIENT / ☐ PARENT / ☐ GUARDIAN ACKNOWLEDGMENT (Please indicate)

I am aware that the information included on this form will be forwarded to the Department of Health (WA).

Name _____

Signature _____ **Date** _____

MEDICAL PRACTITIONER ACKNOWLEDGEMENT

I hereby notify the Chief Executive Officer of Health that the patient will be treated as above in accordance with the Stimulant Prescribing Code and in accordance with a written authorisation from the Chief Executive Officer where required.

Medical Practitioners Signature _____ **Date** _____

Authorised Stimulant Prescriber (SPN holder)		**Nominated Co-Prescriber** ☐ Co-prescribing extends to nominated prescriber only ☐ Co-prescribing extends to all medical practitioners at the same practice	
First Name	Surname	First Name	Surname
SPN		Medical Practice Address	
Medical Practice Address Postcode		Postcode	

The SPN holder is required to provide a copy of this Notification to the Nominated Co-prescriber

Please forward completed form to: **Pharmaceutical Services**, Department of Health, PO Box 8172, PERTH BUSINESS CENTRE WA 6849.
Enquiries: Telephone: 9222 6883, Facsimile: 9222 2463