



Drugs of Dependence Unit

Phone: 1300 652 584

PLEASE RETURN VIA FACSIMILE TO

1300 658 447

TO PRESCRIBE OR SUPPLY A DRUG OF DEPENDENCE FOR A PATIENT WHO HAS RECEIVED TREATMENT FOR A PERIOD
EXCEEDING TWO MONTHS
(Section 18A, Controlled Substances Act)

PRESCRIBER DETAILS:

Prescriber Name :

Prescriber Address:

Post Code:

PATIENT DETAILS:

Patient Name :

Patient Address:

Post Code:

Date of Birth:

Gender:

Occupation:

TREATMENT DETAILS:

Drug (s): .

Dose prescribed / Quantity prescribed per month:

Maximum dose expected to be prescribed:

Date medication commenced:

Expected Period of Treatment:

Condition for which prescribed:

Is it your opinion that the life expectancy of this patient is less than 12 months? Yes No

(Notification only required if ≤ 12 months provided prescriptions are endorsed "NPCP" or "Notified Palliative Care Patient")

Adjunctive drugs/treatment:

If medication ceased-date discontinued:

Reason:

Additional Remarks (including possible dependency issues):

Please indicate if additional reports are attached:

PRESCRIBER SIGNATURE

Signed :

Date:

**PLEASE ANSWER ALL QUESTIONS AND INCLUDE COPIES OF ANY RELEVANT MEDICAL SPECIALIST OR
PAIN CLINIC REPORTS WHICH SUPPORTS TREATMENT WITH DRUGS OF DEPENDENCE**

PLEASE DISCUSS WITH YOUR PATIENT THE PRIVACY ISSUES OUTLINED ON THE REVERSE OF THIS FORM FOR COMPLIANCE WITH COMMONWEALTH
PRIVACY REQUIREMENTS

PRIVACY IMPLICATIONS

THIS SHOULD BE COMPLETED BY THE PATIENT / PARENT OR GUARDIAN UNLESS THE PRIVACY REQUIREMENTS ARE COMPLIED WITH BY OTHER METHODS.

I,, understand that under State legislation, my medical practitioner must obtain authorisation from the Minister responsible for the Controlled Substances Act to prescribe or supply medications in these circumstances. To obtain this authority, my medical practitioner is required to supply information and possibly copies of medical reports concerning my medical condition and treatment. This information is supplied to the Drugs of Dependence Unit to enable proper consideration in issuing or for the maintenance of authorities. All prescriptions for drugs of dependence are forwarded to and monitored by the Unit.

This information is confidential, is only to be accessed by officers within the Drugs of Dependence Unit in managing my case and may only be released where permitted by law, when an opinion is formed that I have not complied with a condition of an issued authority, I have committed an offence against the Act or it is required to be released under a warrant or court order.

Under Freedom of Information Act, I may inspect the information held and correct information as permitted under this Act.

I,, have read all the information on this form and understand this information will be registered with the Drugs of Dependence Unit as application for approval of treatment.

Signed: _____
Where signatory is not the patient named please provide details below

Dated: _____

NAME: _____

ADDRESS: _____
