Government of South Australia
SA Health

File Number:

Drugs of Dependence Unit
Phone: 1300 652 584

PLEASE RETURN VIA FACSIMILE TO
1300 658 447

APPLICATION FOR RENEWAL OF AN AUTHORITY

Your authority to prescribe drugs of dependence for the below patient is due to expire.
Please complete and return this form to the Drugs of Dependence Unit to update this patient's status.
If not returned before the end of the expiry Month, the authority will be ceased and a new application is required.

PRESCRIBER DETAILS:
Prescriber Name :

Prescriber Address:

Post Code:

PATIENT DETAILS:
Patient Name :

Patient Address:

Post Code:

Date of Birth:

TREATMENT DETAILS:
Drug (s): .

Dose prescribed / Quantity prescribed per month:

Any sign of dose increase?

Progress of treatment:

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:

Do you wish authority to continue? ☐ Yes ☐ No

If medication ceased-date discontinued:

Reason:

Additional Remarks *(including possible dependency issues):*

Please indicate if requested or 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

Email Form

Print

Sensitive:Medical(When completed)-I2-A1

Reset Form

P R I V A C Y I M P L I C A T I O N S

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:_____ Dated: _____

Where signatory is not the patient named please provide details below

NAME: _____

ADDRESS: _____

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