

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR; Methylphenidate ER - Teva)

Initial application — ADHD in patients aged 5 years or over

Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing) or nurse practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	ADHD (Attention Deficit and Hyperactivity Disorder) in patients aged 5 years or over
and	
<input type="checkbox"/>	Diagnosed according to DSM-IV or ICD 10 criteria
and	
<input type="checkbox"/>	Applicant is a paediatrician or psychiatrist
or	
<input type="checkbox"/>	Applicant is a medical practitioner or nurse practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing

Initial application — ADHD in patients aged under 5 years

Applications only from a paediatrician or psychiatrist. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	ADHD (Attention Deficit and Hyperactivity Disorder) in patients under 5 years of age
and	
<input type="checkbox"/>	Diagnosed according to DSM-IV or ICD 10 criteria

Initial application — Narcolepsy*

Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

<input type="checkbox"/>	The patient suffers from narcolepsy
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Note: *narcolepsy is not a registered indication for Methylphenidate ER – Teva.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz