

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 Extended Release (Concerta; Ritalin LA)

Initial application — ADHD

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)
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
and	
<input type="checkbox"/>	Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or difficulties with adherence
or	
<input type="checkbox"/>	There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

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