

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

**Dexamfetamine Sulfate**

**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)

The patient suffers from narcolepsy

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](mailto:customerservice@health.govt.nz)