

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:

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)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) in patients aged 5 years or over
- and
- ☐ Diagnosed according to DSM-IV or ICD 10 criteria
- and
- ☐ Applicant is a paediatrician or psychiatrist

or

☐ 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)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) in patients under 5 years of age
- and
- ☐ 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