tph Toowong Private Hospital	(Affix patient identification label here) URN: Family Name: Given Names: Date of Birth: Sex: ☐ M ☐ F

DEXAMPHETAMINE AND METHYLPHENIDATE PRESCRIBING CONFIRMATION FORM

FM346

I am aware of the Royal Australian and New Zealand College of Psychiatrists Practice Guideline 6: Guidelines for the use of Dexamphetamine and Methylphenidate in adults and Practice Guideline 4: The use of medication in dosages and indications outside normal clinical practice and Toowong Private Hospital's PRO367 Dexamphetamine and Methylphenidate Procedure.

I have received a second opinion from (psychiatrist's name) _____ supporting the prescribing of Dexamphetamine / Methylphenidate to (patient's name)

_____

The second opinion is current from _____ to _____ (12 months)

_____

Psychiatrist Print Name

_____ _____

Psychiatrist Signature Date

Pharmacist to complete:

I acknowledge psychiatrist, Dr _____ has stated that the requirements of Toowong Private Hospital's PRO367 Dexamphetamine and Methylphenidate Procedure have been met and will hereby dispense Dexamphetamine and Methylphenidate in accordance with the doctor's prescription.

_____ _____

Pharmacist Signature Date

DEXAMPHETAMINE & METHYLPHENIDATE PRESCRIBING MR / 152