Government of **Western Australia**
Department of **Health**
Public and Aboriginal Health

Termination of Treatment with Stimulant Medicines

1. Notification of termination of treatment with stimulant medicine(s)

Reason for termination: ☐ History of substance abuse in the past 5 years ☐ Diversion/misuse ☐ Bipolar disorder
☐ Oversupplied person ☐ Drug dependant person ☐ Psychosis

Other reason: _____

Stimulant induced psychosis should be reported via the Notification of Stimulant Induced Psychosis

2. Patient details

First name: _____ Surname: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Aliases: _____ Gender: ☐ Male ☐ Female ☐ Unspecified

Medicare number: _____

Is this person of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

3. Condition for which treatment has been terminated

☐ ADHD ☐ Acquired brain injury ☐ Narcolepsy ☐ Depression ☐ Binge eating disorder

☐ Other: _____

4. Concurrent psychotropic medicines

Is the patient currently prescribed other psychotropic medicines?

☐ No ☐ Antidepressants ☐ Anxiolytics ☐ Antipsychotics ☐ Mood stablilisers

☐ Other, specify: _____

5. Treatment details at the time of termination

Dexamfetamine (mg/day) _____ Methylphenidate (mg/day) _____

Dexamfetamine compound (mg/day) _____ Methylphenidate long-acting (mg/day) _____

Lisdexamfetamine (mg/day) _____

6. Prescriber details

First name: _____ Surname: _____

AHPRA/Prescriber number: _____ Practice/ hospital name: _____

Is the patient being treated at a Registered Public Clinic: ☐ Yes ☐ No

Address: _____ Suburb: _____ Postcode: _____

Telephone _____ Fax: _____ Practice email: _____

7. Shared care practitioner (nurse practitioner or medical practitioner)

☐ Send a copy of this completed form to the shared care practitioner ☐ No shared care practitioner

First name: _____ Surname: _____

Practice name: _____ Contact email: _____

Practice address: _____

8. Prescriber declaration

I hereby notify the Chief Executive Officer of the Department of Health of termination of treatment with stimulant medicines in accordance with the *Monitored Medicines Prescribing Code.* I declare that information provided in this notification is true and correct to the best of my knowledge. I confirm that I have made the patient/parent/guardian aware that the information included on this form will be forwarded to the Department of Health of Western Australia to meet legislative requirements and this information may be provided to authorised health professionals to assist with the management of the patient or used (when de-identified) for the purpose of authorised research.

Signature: _____ Date: _____

Send completed form to: Medicines and Poisons Regulation Branch
Department of Health, PO Box 8172, Perth Business Centre WA 6849
Facsimile: 9222 2463 **Enquiries:** Tel 9222 2483 **Email** MPRB@health.wa.gov.au
And copy to the shared care practitioner