NSW GOVERNMENT | Health

INT05/18

Application for Temporary Interstate Transfer to NSW Opioid Treatment Program

This form is to be used only for short term transfers. For other transfers, complete an 'Application for Authority to Prescribe Methadone or Buprenorphine under the NSW Opioid Treatment Program' form (http://www.health.nsw.gov.au/pharmaceutical).

This form is available online in PDF format (http://www.health.nsw.gov.au/pharmaceutical) and should be filled in electronically using a computer. If completing the form by hand, please use BLOCK LETTERS and ensure that all details are legible.

Eligible applications are generally processed within 2 business days.

Section A: Details of patient transferring to NSW
Patient Family Name:
Patient Given Names: *(first names)* *(middle name)*
Also known as: *(first names)* *(family name)*
Patient Residential Address in NSW: **Suburb/Town:** **Postcode:**
Patient Date of Birth: __ __ ____ **Sex:** ☐ M ☐ F
Has the patient previously been enrolled on the NSW Opioid Treatment Program? ☐ Y ☐ N
Section B: Transfer details
Current dose *(complete as applicable)*: ☐ methadone .... mg ☐ buprenorphine .... mg Regimen *(e.g. daily dosing, second day dosing)*: ....
Date of last dose *(including any takeaway doses)*: __ __ ____ *Note: This is the last dose administered prior to transfer to NSW*
Proposed starting date for treatment in NSW: __ __ ____
Proposed end date for treatment in NSW *(including any takeaway doses)*: __ __ ____
Name of proposed dosing point in NSW: .... **Suburb/Town:** ....
Proposed starting dose in NSW: .... mg ☐ methadone ☐ buprenorphine *Note: A valid prescription must be forwarded directly to the clinic or pharmacy where dosing will take place. Do not send the prescription with the patient.*
Section C: Details of interstate prescriber
Prescriber Name: *(first names)* *(family name)*
Name of Practice: **Address:** **Suburb/Town:** **Postcode:**

Telephone:	Fax:	Email:

AHPRA Registration No:	PBS Prescriber No:

Is the prescriber an authorised opioid pharmacotherapy prescriber in their home state/territory?

☐ Y → *To facilitate processing of this application, attach a copy of the authorisation issued by the state/territory authority where available*

☐ N

Section D: Declaration

I confirm that the information I have provided in this application is true and complete to the best of my knowledge.

Signed: .... Date: __ __ __ __ __ __ __ __

Name *(if not the interstate prescriber listed above)*: ....

Privacy Statement: The information set out in this form is required by the Ministry of Health for the issuance of an authority to prescribe a Schedule 8 drug as required under the law. The collection, use and disclosure of the information provided will be in accordance with privacy laws. The information collected may be disclosed to health practitioners when necessary to facilitate coordination of treatment and patient safety. Personal information will not be disclosed for any other purpose without prior consent, except where required by law or where otherwise lawfully authorised to do so. The application may not be processed if all information requested on the form is not completed. For further information on privacy visit http://www.health.nsw.gov.au/patients/privacy. For further advice or clarification please email MOH-PharmaceuticalServices@health.nsw.gov.au

Fax completed form and supporting documentation to the Pharmaceutical Regulatory Unit: 02 9424 5885
Enquiries: Tel 02 9424 5921. Allow up to 2 business days for the processing of applications.