STRICTLY CONFIDENTIAL PHARMACEUTICAL SERVICES NSW MINISTRY OF HEALTH

APPLICATION FOR TEMPORARY INTERSTATE TRANSFER TO NSW OPIOID TREATMENT PROGRAM

Note: *This form is to be used only for transfers for a period of one month or less. For other transfers, complete an 'Application for Authority to Prescribe Methadone' or 'Application for Authority to Prescribe Buprenorphine' form.*

Patient ID No : *[OFFICE USE ONLY]*

Section A: Details of patient transferring to NSW

1. PATIENT SURNAME: .....
2. GIVEN NAMES: ..... ALSO KNOWN AS: .....
3. ADDRESS IN NSW: .....
4. SUBURB/TOWN: ..... 5. POSTCODE: .....
6. DATE OF BIRTH: __ __/__ __/__ __ __ __ 7. SEX: M ☐ F ☐
8. HAS THE PATIENT PREVIOUSLY BEEN ON A BUPRENORPHINE OR METHADONE PROGRAM IN NSW? Y ☐ N ☐

Section B: Details of transfer

9. CURRENT DOSE (complete as applicable):
   METHADONE DOSE: ..... MG
   BUPRENORPHINE DOSE: ..... MG REGIMEN *(eg. daily, second day dosing)*: .....
10. DATE OF LAST DOSE: (INCLUDE TAKE AWAY DOSES): __ __/__ __/__ __ __ __
    Note: This is the last dose administered prior to transfer to NSW.
11. PROPOSED STARTING DATE FOR TREATMENT IN NSW: __ __/__ __/__ __ __ __
12. PROPOSED END DATE FOR TREATMENT IN NSW (INCLUDE TAKE AWAY DOSES): __ __/__ __/__ __ __ __
13. PROPOSED DOSING POINT IN NSW: ..... SUBURB: .....
14. 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 to the dosing point with the patient.

Section C: Details of interstate prescriber

15. NAME: Dr / Prof .....
16. NATIONAL REGISTRATION NUMBER: .....
17. PRACTICE/CLINIC ADDRESS: .....
18. SUBURB/TOWN: .....
19. POSTCODE: ..... 20. STATE/TERRITORY: .....
21. PH: ( ) ..... 22. FAX: ( ) .....
23. IS THE PRESCRIBER AN AUTHORISED OTP PRESCRIBER IN THEIR HOME STATE/TERRITORY? Y ☐ N ☐
    Note: To facilitate this application, please attach a copy of the authorisation issued by the state health authority, if available.

PRESCRIBER/COORDINATOR SIGNATURE: ..... Date: __ __/__ __/__ __ __ __

Fax to: Pharmaceutical Services
NSW Ministry of Health
Locked Mail Bag 961, North Sydney NSW 2059
Telephone: (02) 9424 5921
Facsimile: (02) 9424 5885

Last Updated 25/09/2012