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| 1. **Prescriber details** | | | | | | | | | | | | | | | | | | | | | | |
| First name: | | | |  | | | | | | | | Surname: | | |  | | | | | | | |
| Prescriber number: | | | | |  | | | | AHPRA registration number: | | | | | | | | |  | | | | |
| Practice name: | | | | |  | | | | | | | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | Suburb: | |  | | | | | | Postcode: | |  |
| Telephone: | | |  | | | Fax: | |  | | | | Practice email: | | | |  | | | | | | |
| Do you have any restrictions placed on your Schedule 8 prescribing by any authority? | | | | | | | | | | | | | | | | | | | | | | |
| Yes, please provide details: | | | | | | | ­­­ | | | | | | | | | | | | | | No | |
| Approved Prescriber eligibility category, please attach documentation: | | | | | | | | | | | | | | | | | | | | | | |
|  | Medical practitioner approved by the TGA as an “Authorised Prescriber” | | | | | | | | | | | | | | | | | | | | | |
|  | Medical practitioner prescribing for patients enrolled in a clinical trial approved  by a Human Research Ethics Committee | | | | | | | | | | | | | | | | | | | | | |
|  | Relevant specialist medical practitioner (please specify in Section 2) | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Specialist category** | | | | | | | | | | | | | | | | | | | | | | |
|  | | Neurologist | | | | | | | | |  | | Rehabilitation Physician | | | | | | | | | |
|  | | Other, please specify: | | | |  | | | | | | | | | | | | | | | | |
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| 1. **Applicant declaration** | | | | | | | | | | | | | | | | | | | | | | |
| I understand and will comply with the requirements for Cannabis-Based Product prescribing in Western Australia as set out in the *Medicines and Poisons Regulations 2016* and *Schedule 8 Medicines Prescribing Code* including:   * submitting a *Notification of Treatment: Cannabis-Based Products* form when initiating treatment with Cannabis-Based Products, when patient or co-prescriber details change, or when treatment is ceased; * obtaining prior written individual patient authorisation from the Chief Executive Officer of the Department of Health where required by the *Schedule 8 Medicines Prescribing Code;* * participating in audits concerning the prescribing of Cannabis-Based Products if required by the Department of Health; and * advising the Medicines and Poisons Regulation Branch if any details on this form change. | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | | |  | | | | | | | | | | | Date: | | |  | | | | | |
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| **Office Use Only** | | | | | | | | | | | | | | | | | | | | | | |
| Approval number: | | | |  | | | | | |  | | | | | | | | | | | | |
| Processed by: | | | |  | | | | | | Date: | |  | | | | | | |  | | | |
| Checked by: | | | |  | | | | | | Date: | |  | | | | | | |  | | | |
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