Medication Purpose – Doctor Approved

This form is to be completed by the participants prescribing doctor. The aim of this information is to clarify whether any medications are prescribed for behavioural purposes, as per the Disability Act 2006 and the NDIS Commission’s restrictive practice policy (Chemical Restraint).

To ensure accurate information is obtained in a timely manner, Kyeema Support Services requires some information about prescription and non-prescription medication that may be used to manage behaviours of concern.

|  |  |
| --- | --- |
| Date of Visit: |  |
| Participant Name: |  | Date of Birth: |  |
| NDIS # |  |
| Support person attending consult: |  |

|  |  |
| --- | --- |
| Treating practitioner’s name: |  |

|  |  |
| --- | --- |
| Signature: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you the individual’s regular treating practitioner? | Yes |  | No |  |
| General practitioner |  | Psychiatrist |  | Neurologist |  |
| OR specify |  |
| Clinic address: |  |
| Has a medication treatment sheet been provided? | Yes |  | No |  |

|  |  |
| --- | --- |
| Current Diagnosis(*if the first date of diagnosis is known, please indicate*) |  |

**Medication**

|  |  |
| --- | --- |
| **Medication name:** | **Schedule:** S4 [ ]  S4(D) [ ]  S8 [ ]  |
| **Dose:** |
| **Route** (eg. gargle, swallow, rectum): |
| **Frequency** (e.g. 2x daily, 4 hourly, 1x3 weekly): |
| **Total dose across day:** |
| **Circle – Routine / PRN** |
| **If PRN, maximum dose across day and instructions for use:** |
| **Side effects** displayed by participant (e.g. none, drowsiness, confusion) |
| **Purpose of medication** 1. Is this medication used for diagnosed conditions? Circle ***Yes / No***
 |
| *If yes*, name of diagnosed condition:*If no*, reason for the medication: |
| **Give details** of the diagnosed condition e.g. |
| * Physical illness or condition – details
 |
| * Mental health diagnosis – details
 |
| * Behaviour management – details
 |
| * Other - details
 |
| 1. Is the **primary purpose** of the medication to influence or change behaviour?

Circle ***Yes / No***If there is no diagnosed condition, the use of this medication will be considered a restrictive practice.  |

**Medication**

|  |  |
| --- | --- |
| **Medication name:** | **Schedule:** S4 [ ]  S4(D) [ ]  S8 [ ]  |
| **Dose:** |
| **Route** (eg. gargle, swallow, rectum): |
| **Frequency** (e.g. 2x daily, 4 hourly, 1x3 weekly): |
| **Total dose across day:** |
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| * Physical illness or condition – details
 |
| * Mental health diagnosis – details
 |
| * Behaviour management – details
 |
| * Other - details
 |
| 1. Is the **primary purpose** of the medication to influence or change behaviour?

 Circle ***Yes / No***If there is no diagnosed condition, the use of this medication will be considered a restrictive practice.  |

*Please file this form in the participant’s folder, both as a hard copy and electronically.*