



**Health New Zealand**  
**Te Whatu Ora**  
 Te Pae Hauora o Ruahine o Tararua  
 MidCentral

**PRIMARY CARE PRACTITIONER ADHD SPECIAL AUTHORITY**  
**RENEWAL APPLICATION FOR METHYLPHENIDATE**  
*For patients age 18 years and over*

**IF CLIENT PRESENTS WITH ACUTE CONCERNS AND/OR RISK, PLEASE CALL 0800 653 357.**

<b>Person Details</b>	Surname:	Given name:
	NHI:	D.O.B:
	Ethnicity:	Contact number:
	Allergies:	Contact email:
	Referrer name:	Referrer phone:
		Referrer email:
	Medication for S.A/CHEM Number:	Expiry date:

The GP or NP prescribing methylphenidate is responsible for ongoing evaluation and monitoring of the person receiving treatment. This includes assessment of physical health and side effects from methylphenidate, effectiveness of treatment and assessment of risk of medication diversion.

For further information about assessment and monitoring of medications used to treat ADHD, please go to:

[What is ADHD | ADHD NZ - ADHD NEW ZEALAND](#) | [ADHD Association Inc. • Healthpoint](#)

For queries or advice about ADHD management options please contact Specialist Primary Mental Health and Addiction Services on: [MHASSPNon-UrgentGPQuery@midcentraldhb.govt.nz](mailto:MHASSPNon-UrgentGPQuery@midcentraldhb.govt.nz)

<p><b>Was the diagnosis of ADHD made by a MidCentral clinician?</b></p> <p>Yes    No</p>	<p>If <b>yes</b> - please give year and name of clinician if known:</p> <p>If <b>no</b> - please attach a previous paediatric/mental health specialist letter regarding the diagnosis. If the diagnostic assessment is available, please send this.</p> <p><b>If there is no diagnosis or paediatrics/mental health specialist letter, please contact the Specialist Primary MH &amp; Addiction team to discuss on:</b></p> <p><a href="mailto:MHASSPNon-UrgentGPQuery@midcentraldhb.govt.nz">MHASSPNon-UrgentGPQuery@midcentraldhb.govt.nz</a></p>
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**What dose and formulation of medication is the person taking?**

<p><b>Has the dose of formulation changed since the last renewal?</b></p> <p>Yes    No</p>	<p>If <b>yes</b> - what changes have been made?</p>
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<p><b>Is the medication helping with symptoms of ADHD?</b></p> <p>Yes    No</p>	<p>Please describe:</p>
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<p>Have there been side effects of concern?</p> <p>Yes    No</p>	<p>If <b>yes</b> - please describe (<i>mood changes, irritability, weight loss, palpitations, tachycardia, or fainting.</i>)</p>
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<p>Are there any concerns regarding diversion or misuse?</p> <p>Yes    No</p>	<p>If <b>yes</b> - please describe:</p>
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Please give further details (*mental/emotional/physical/social/family history etc & attach as much supplementary information as possible*):

<p>Outcome renewal approved?    Yes    No</p>
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<p>Reason for non-approval:</p>	<p>Describe:</p>
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<p>Approving or non-approving consultant name/signature and date of approval:</p>	
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**This form when completed should be scanned and sent to referrer on outcome.  
GP or NP can complete special authority renewal  
on receipt of this form if request is approved by consultant.**