VOLUNTARY UNDERTAKING

I ____

Of ____

(DOB) _____ / _____ / _____   Medicare Number _______ _________ __

voluntarily agree to the conditions, as set out below for a period of six months.

I understand that the purpose of the undertaking is to prevent me obtaining prescriptions for the following medicines from more than one doctor:

☐ Benzodiazepines

☐ Opioids (e.g. morphine, oxycodone)

☐ Other (e.g. 'codeine-containing preparations') __________________________

Please tick and/or insert name of medicine as necessary

I agree I will only obtain prescriptions for these medicines from:

Dr ____________________ of ____________________________________

Ph: _________________   Fax: _________________as discussed and agreed.

And that I will pick up these prescriptions only from ____________________Pharmacy

at ____

Ph: _________________   Fax: _________________

I agree that a copy of this signed undertaking will be sent to the Health Protection Services who may advise doctors and pharmacies about the Undertaking.

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I understand that should circumstances change this Undertaking can be cancelled by my doctor, pharmacist or me and written advice will be sent to the Health Protection Service.

Signed: ______________________________ Signed: Dr ___________________________

Print Name: __________________________ Print Name: __________________________

Date: _____ / ______ / ______ Date: ______ / ______ / _____

Witnessed by ________________________ Signed: ______________________________

Date: _____ / ______ / ______

Please verify that the nominated pharmacy is willing to participate in this voluntary undertaking before it is signed and sent to the Health Protection Service.

The information above is confidential and is intended for use by, the Health Protection Service.

Locked Bag 5005, Weston Creek 2611

Telephone: (02) 5124 9208 Fax: (02) 5124 9309

Accessibility

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