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.

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 Email: HPS@act.gov.au

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