The purpose of this form is to assist disability service providers and treating practitioners to identify and or clarify any medication(s) that may be classified as a restrictive practice (chemical restraint).

Section 6(b) of the [NDIS (Restrictive Practices and Behaviour Support) Rules 2018](https://www.legislation.gov.au/Details/F2018L00632) defines chemical restraint as:

‘the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition’.

To use this form:

* Disability service provider populates form as much as possible prior to Participant medication review
* Medical practitioner completes medication purpose information
* Medication purpose form is kept on Participant file and submitted with any restrictive practice authorisation request (where relevant)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of person:** |  | **Date of birth:** |  | **Date of visit:** |  |

|  |  |
| --- | --- |
| **Residential address:** |  |

|  |  |
| --- | --- |
| **Support person attending consult:** |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Number:** |  | **Signature:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you the individual’s regular treating practitioner?** | Yes | [ ]  | No | [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| **General practitioner**[ ]  | **Psychiatrist**[ ]  | **Neurologist**[ ]  | **Other**[ ]  |

|  |  |
| --- | --- |
| **Clinic address:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have medication information sheets been provided?** | **Yes** |  | **No** |  |

|  |  |  |
| --- | --- | --- |
| **Date of last annual health check** | **Date:** |  |

|  |
| --- |
|  **Medication 1**  |
| **Medication:** (Generic name) |  | **Dose:** |  |
| [ ]  **Is the medication within the recommended daily dose?** |
| **Purpose of the Medication** |
| [ ]  **Physical Illness or condition** | Specify: |  |
| [ ]  **Behavioural Support**  | Specify: |  |
| [ ]  **Mental health diagnosis** | Specify:  |  |
| [ ]  **Other**  | Specify:  |  |

|  |
| --- |
|  **Medication 2** |
| **Medication:** (Generic name) |  | **Dose:** |  |
| [ ]  **Is the medication within the recommended daily dose?** |
| **Purpose of the Medication** |
| [ ]  **Physical Illness or condition** | Specify: |  |
| [ ]  **Behavioural Support**  | Specify: |  |
| [ ]  **Mental health diagnosis** | Specify:  |  |
| [ ]  **Other**  | Specify:  |  |

\*Service Provider to cut and paste additional medication table(s) as necessary.