



Kimberley Aboriginal Medical Services Council

WA Country Health Service  
Government of Western Australia  
Kimberley

<b>KSDL Individual Patient Supply Form</b> (Prescriber to complete for patients who require a <b>\$100</b> medicine that is <b>NOT</b> on the KSDL)
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OR

<b>Modification Request form</b> (For general requests for addition/amendments on the KSDL)
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**Note:** *For KSDL individual patient supply:-  
Signing of this form constitutes your acceptance of the following condition:  
The drug will **only** be used for the named patient identified below  
(This is a requirement of the KSDL implementation policy – an approved policy of the  
Kimberley Medical Advisory Committee and the Executive of WACHS-Kr)*

Patient name: (not necessary for KSDL modification requests)	DOB : __/__/__
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Drug Name and strength:
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Quantity required: (up to maximum of 6 month supply)
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Rationale for Prescription or Reason for Addition on the KSDL: (i.e. why was a drug from the KSDL not appropriate in this instance)
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Prescriber name (please print and sign):	Date:
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Prescriber location:	Date:
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**Note:**  
∞ *Please advise your patient that this medicine will not be routinely available from other KHR or AMS clinics and so to ensure continuity of supply they must return to the clinic (or hospital) from which they obtained their initial supply*

**Please return this form to either:**  
(i) *Regional Pharmacist (Fax: 08 9192 3884, POST: Broome Health Services, PO Box 62, Broome WA 6725 or EMAIL: [Roy.Finnigan@health.wa.gov.au](mailto:Roy.Finnigan@health.wa.gov.au)*  
(ii) *KAMSC Pharmacist (Fax: 08 9192 2500, POST: KAMSC, PO Box 1377, Broome WA 6725 or EMAIL : [corinap@kamsc.org.au](mailto:corinap@kamsc.org.au)*