This document has been approved for use at [ ]

Streamlined IPU Declaration Form
Temazepam for Sleep Disturbance in Non-Critically Ill Treatment-Naïve^ Adults

This form should be completed prior to prescribing temazepam for sleep disturbance/insomnia in treatment-naïve patients^. Failure to meet the requirements of this form will necessitate a full IPU application. The form should be completed by a consultant or registrar.

^A treatment-naïve patient is a patient who has not taken a medicine for night sedation more than three times in the last 2 weeks.

A. Patient Details

Affix patient label or provide details →	MRN:
	Given names:
	Family name:
	D.O.B or Age:
	Address:

B. Medicine Name and Proposed Dose

Name	Proposed dose
Temazepam 10mg tablet	☐ **5mg at night PRN for sleep** OR ☐ **10mg PO at night PRN for sleep** (Tick dose. Note: 5mg is the recommended dose for older patients)

C. Other Treatment Details

I declare that (tick as appropriate):

☐ the patient does not regularly take temazepam or other benzodiazepines (when at place of residence);

☐ other non-pharmacological approaches, including addressing modifiable causes, have been tried and proven inadequate (but will continue);

☐ sleep disturbance is causing significant distress or harm;

☐ an assessment of the harm to benefit ratio from benzodiazepine use has been undertaken (see Checklist documentation);

☐ the patient is aware of and counselled on the potential harms and benefits, and has provided informed consent (form/verbal guide available);

☐ the initial prescription is for a 'trial' period of 1-3 nights, until the patient is next reviewed by the treating team to decide whether to continue it 'PRN';

☐ if continued after the 'trial' period, the cause of the sleep disturbance, the effect of temazepam on sleep during the trial period, and the effect of other initiated sleep management modalities will be documented in the clinical record;

☐ the treating team will regularly review effectiveness and safety;

☐ the prescription of temazepam will NOT be longer than 2 weeks; and,

☐ the prescription of the temazepam will NOT be continued at discharge or transfer to another unit.

D. Supporting documentation & declaration

☐ *Attach the competed "Checklist for managing sleep complaints in hospitalised non-critically ill adult patients (undertaken in consultation with patient and/or carer)"*

I, _____ , of Treating Team _____,

Name of Consultant or Registrar

have determined it is clinically appropriate to initiate temazepam for inpatient treatment of sleep disturbance for the patient identified above.

►Forward completed form to the Pharmacy Department/ local Drug and Therapeutics Committee delegate

FOR DTC USE ONLY

Date received:

Signed *on behalf of the DTC*: _____ Name:

NSW TAG NSW Therapeutic Advisory Group Inc.