Psychedelic Assisted Therapy

Data collection form: Treatment outcomes and adverse events

In NSW, authorised prescribers of psychedelic assisted therapy (PAT) are required to submit treatment outcome and adverse event data to NSW Health on a regular basis. This allows for additional monitoring given the limited and emerging evidence base for PAT.

Data should be submitted to NSW Health at the time of initial PAT session, 3-months, 6-months and 12-months post treatment.

Fax completed form to the Pharmaceutical Services Unit:
Fax: (02) 9424 5889 or email to: MOH-S8Auth@health.nsw.gov.au

Treatment outcome reporting requirements

- Patient's receiving PAT for treatment resistant depression require a pre-treatment MADRS, which needs to be repeated at 3-months, 6-months and 12-months after the initial treatment session
- Patient's receiving PAT for post-traumatic stress disorder require a pre-treatment PCL-5, which needs to be repeated at 3-months, 6-months and 12-months after the initial treatment session

Adverse events reporting requirements

- Adverse events need to be reported for during each dosing session and at 3-months, 6-months and 12-months after the initial treatment session
- Consider both psychological and physical adverse events

TREATMENT DETAILS

Authorised prescriber: _____

Patient name: _____

Patient date of birth: _____ (*dd/mm/yyyy*)

Patient identification number: _____ *(For office use)*

Treatment location: _____

Treatment dates: _____ (*dd/mm/yyyy*)

Treatment medication administered: _____

Diagnosis 1: _____

Diagnosis 2 (optional): _____

Additional mental health diagnoses (optional): _____

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TREATMENT OUTCOMES

	Pre-treatment	3-months post	6-months post	12-months post
MADRS				
PCL-5				

ADVERSE EVENT OUTCOMES

For each adverse event please also complete the adverse event reporting form

Treatment session	3-months post	6-months post	12-months post

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ADVERSE EVENT REPORTING FORM

Authorised prescriber: _____

Patient name: _____

Patient date of birth: _____ (*dd/mm/yyyy*)

Patient identification number: _____ *(For office use)*

Treatment location: _____

Treatment dates: _____ (*dd/mm/yyyy*)

Treatment medication administered and dose: _____

Time to adverse event since treatment: _____

Description of adverse event: _____

Severity of adverse event (i.e. life threatening, hospitalised, required further medical attention):

Treatment of reaction:

Outcome (i.e. recovered, not yet recovered, fatal):

Sequelae (i.e. no, yes – describe):