Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1981
November 2021

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Ketorolac trometamol

Initial application — macular oedema
Applications only from an ophthalmologist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

☐ The patient has established post-operative or inflammatory (uveitic) cystoid macular oedema

or

☐ The patient is at risk of postoperative macular oedema

and

☐ The patient has had, or is scheduled to have imminent cataract surgery

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz