Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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: Fat (Calogen; Liquigen; MCT oil (Nutricia))		Fax Number:
Initial application — Inborn errors of metabolis Applications only from a dietitian, relevant specialis Prerequisites(tick box where appropriate) The patient has an inborn error of metabolis	st or vocationally registered general practitioner. App	rovals valid without further renewal unless notified.
Initial application — Indications other than inborn errors of metabolism Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year. Prerequisites(tick boxes where appropriate)		
D of the Pharmaceutical Schedule	ılar formula made from at least one nutrient module a	·
dietitian, relevant specialist or vocationally registers Prerequisites(tick box, and write the data requesters)	st, vocationally registered general practitioner or general general practitioner. Approvals valid for 1 year. ed in the space provided where appropriate)	eral practitioner on the recommendation of a
and	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally	y registered general practitioner and date

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