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:
	chly from a dietitian, relevant specialism (tick boxes where appropriate)  Child is aged one to ten years  The child is being fed via a to any condition causing malable relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant require relationship for the faltering growth in an infant relationship for the faltering growth growt	'child	
Applications o dietitian, relev	ant specialist or vocationally registers (tick box, and write the data request	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
	neral Practitioners must include the n	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationall	

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