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 N	No:	First Names:	First Names:
Name	):	Surname:	Surname:
Address:		DOB:	Address:
		Address:	
Fax N	lumber:		Fax Number:
Spec	cialised And Elemental Products		
Appl Pren Note Elem	equisites(tick boxes where appropriate)  Malabsorption or Short bowel syndrome or Enterocutaneous fistulas or Eosinophilic oesophagitis or Inflammatory bowel disease or Patients with multiple food allergie : Each of these products is highly specialised	st or vocationally registered general practitioner. App s requiring enteral feeding and would be prescribed only by an expert for a spe products listed in this section and should only be use	cific disorder. The alternative is hospitalisation.
Appl dietit	ent approval Number (if known):ications only from a dietitian, relevant speciali	st, vocationally registered general practitioner or gene ed general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
	and General Practitioners must include the r	e and the patient is benefiting from treatment name of the dietitian, relevant specialist or vocational	

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