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:		Fax Number:
Naltrexone		
Initial application Applications from any relevant practitioner. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate) Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence and Applicant works in or with a community Alcohol and Drug Service contracted to Health NZ or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard		
Renewal Current approval Number (if known):		
Compliance with the medication (prescriber determined)		
Patient is still unstable and re	equires further treatment	
or Patient achieved significant improvement but requires further treatment		
Patient is well controlled but	requires maintenance therapy	

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