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 N				Fax Number:
Initial application Applications from any relevant practitioner. Approvals valid for 2 months.  Prerequisites(tick boxes where appropriate)				
	and	Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli		
		Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin amoxicillin with clavulanic acid, and norfloxacin  The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxic with clavulanic acid, and norfloxacin that the pathogen is susceptible to		
Renewal  Current approval Number (if known):				
	and	Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli		
		Microbiological testing confir amoxicillin with clavulanic ac	ms the pathogen is resistant to all of: trimethoprim, r id, and norfloxacin	nitrofurantoin, amoxicillin, cefaclor, cefalexin,
		The patient has a contraindic	cation or intolerance to all of: trimethoprim, nitrofurar floxacin that the pathogen is susceptible to	ntoin, amoxicillin, cefaclor, cefalexin, amoxicillin

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