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:
Betaine		
Initial application Applications only from a metabolic physician. Approvals valid for 12 months. Prerequisites(tick boxes where appropriate) The patient has a confirmed diagnosis of homocystinuria and A cystathionine beta-synthase (CBS) deficiency or A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency or A disorder of intracellular cobalamin metabolism and An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation		
Renewal Current approval Number (if known):		

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