

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:

Linezolid

Initial application — multi-drug resistant tuberculosis
Applications from any relevant practitioner. Approvals valid for 18 months.

Prerequisites(tick boxes where appropriate)

☐ The person has multi-drug resistant tuberculosis (MDR-TB)

and

☐ Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends linezolid as part of the treatment regimen

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

Signed: Date:
Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz