

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)

and	<input type="checkbox"/> The person has multi-drug resistant tuberculosis (MDR-TB) <input type="checkbox"/> Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends linezolid as part of the treatment regimen
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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