

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**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: .....

## Diabetic Products (Diasip; Diason; Glucerna; Glucerna RTH; Resource Diabetic; Resource Diabetic RTH)

### INITIAL APPLICATION

Applications only from a relevant specialist. Approvals valid for 1 year.

**Prerequisites** (tick boxes where appropriate)

Type I and II diabetics who require nutritional supplementation  
and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

### RENEWAL

Current approval Number (if known):.....

Applications only from a relevant specialist or general practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.

**Prerequisites** (tick boxes, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment  
and

The product is to be used as a supplement (maximum 500 ml per day)

or

The product is to be used as a complete diet

and  
General Practitioners must include the name of the specialist and date contacted: .....

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

Signed: ..... Date: .....