

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:

Macrogol 3350

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

the patient has problematic constipation requiring intervention with a per rectal preparation despite an adequate trial of other oral pharmacotherapies including lactulose where lactulose is not contraindicated

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

the patient is compliant and is continuing to gain benefit from treatment

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

Signed: Date: