

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:

Midodrine

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- Disabling orthostatic hypotension not due to drugs
and
 Patient has tried fludrocortisone (unless contra-indicated) with unsatisfactory results
and
 Patient has tried non pharmacological treatments such as support hose, increased salt intake, exercise, and elevation of head and trunk at night

Note:

Treatment should be started with small doses and titrated upwards as necessary.
Hypertension should be avoided, and the usual target is a standing systolic blood pressure of 90 mm Hg.

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

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

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

Signed: Date: