

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:

Fentanyl patches

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Patient is terminally ill and is opioid-responsive

and

is unable to take oral medication

or

is intolerant to morphine, or morphine is contraindicated

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 3 months.

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: