Directorate Pharmaceutical Policy and Monitoring
Administration Building
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MEU
MEDICINES
ENTITLEMENT UNIT

Exceptional Medicinal Treatment Request Form

Patient's Name: _____

Date of Birth: _____ **I.D. Card No:** _____

Address: _____

Request 1: **First application** ☐ **Renewal** ☐

Entitlement to Free Medicines: ☐ Schedule V Condition _____
☐ Schedule II

Medication Requested: _____ **Dosage Form and Strength:** _____

Dosage regimen: _____ **Expected Duration of Therapy:** _____

Clinical Indications: _____

_____

Reason/s why this drug is requested: _____

_____

_____

_____

_____

Further documentation needed: Laboratory results etc. _____

_____ _____
Signature of Consultant Name in Block Letters and Registration Number

_____
Date

This form will be returned to the Consultant if any section is not completed.

Data Protection Statement
All personal data is required to provide you with health care services as necessary, and is processed in accordance with the Data Protection Act, and as permitted by law. Further information about your data can be obtained on request.