Feidhmeannacht na Seirbhíse Sláinte Health Service Executive	**GMS (HARDSHIP) ASSISTANCE APPLICATION**	HD1

Section A should be completed and signed by the patient. Section B should be completed by the Doctor and Pharmacist. The form should then be sent to your HSE Local Health Office.

****

SECTION A: ***To be completed by the patient:***

First Name:																		
Surname:																		
Address:																		

Medical Card No:								

Expiry Date:			/		
		month		year	

PPSN:									

Personal Public Service Number (available from your Tax Cert, P60, P45, payslip or Social Welfare book)

DATA PROTECTION NOTICE:

- The information on this form will be used by the Health Services Executive (HSE) to assess the suitability of the items listed below, to be provided free of charge to the person named on the form.
- Details of prescription items dispensed to the named person may be notified to the HSE by the dispensing Pharmacist to ensure that the named person receives the items required free of charge.
- The named person may access information relating to themselves only, on prescription claims processed in their name by the HSE.

I wish to apply for the cost of the drugs below to be paid for by the HSE,

Signature:	

Date:	/ /
	Day month Year

****

- **SECTION B:** ***To be completed by the Doctor and priced by the Pharmacist: Please complete all sections***

I hereby certify that .....is under my care for the treatment of ……..

…… and requires the following item/s which are not on the List of GMS Reimbursable Items:

	Item Required	Weekly / Monthly Quantity as per Rx	Weekly / Monthly Ingredient cost
1.			
2.			
3.			
4.			

DOCTOR'S STAMP

PHARMACY STAMP

Doctor's Signature……. Pharmacist's Signature …….

****

For Office Use Only

Approved/Refused: …….....……Date:…/…./…… Expiry of approval...../...../.....