St. Vincent's Hospital – IPU Declaration for everolimus in Lymphangioleiomyomatosis

Patient Details (Place patient label)	MRN: Family name: Given names Address:

Indication for use (please tick)

❒ Lymphangioleiomyomatosis

❒ Other (please specify) ____

____

____

Proposed dose: ____

Proposed trial duration of therapy: ___________________________

(maximum 6 months)

Proposed commencement date: _____________________________

Follow-up appointment has been arranged with Dr __________________ on _____/_____/______

Please note following the initial trial period (maximum 6 months) a report on outcomes of therapy is required for submission to the Drug and Therapeutics Committee to enable ongoing supply.

Other comments

____

____

____

Requested by

Name of Applicant			
Position / Appointment			
Signature		Date	