

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Adrenaline**

**Initial application — anaphylaxis**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- |           |  |
|-----------|--|
| <b>or</b> | <input type="checkbox"/> Patient has experienced an anaphylactic reaction which has resulted in presentation to a hospital or emergency department |
|           | <input type="checkbox"/> Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner                             |

- and**  Patient is not to be prescribed more than two devices in initial prescription

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

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)