

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:

Adrenaline

Initial application — anaphylaxis

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

Prerequisites(tick boxes where appropriate)

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