

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:

Potassium Citrate

Initial application
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

The patient has recurrent calcium oxalate urolithiasis
and
 The patient has had more than two renal calculi in the two years prior to the application

Renewal
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient is benefitting from the treatment

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