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|--|---------------------------|-------------------------------|
| 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: |

Arginine

Initial application

Applications only from a metabolic physician. Approvals valid for 6 months.

Prerequisites(tick box where appropriate)

Patient has a suspected inborn error of metabolism that may respond to arginine supplementation

Renewal

Current approval Number (if known):.....

Applications only from a metabolic physician. Approvals valid for 24 months.

Prerequisites(tick boxes where appropriate)

| | |
|---|---|
| <p><input type="checkbox"/></p> <p>and</p> <p><input type="checkbox"/></p> | <p>The patient has a confirmed diagnosis of an inborn error of metabolism that responds to arginine supplementation</p> <p>The treatment remains appropriate and the patient is benefiting from treatment</p> |
|---|---|

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