

<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: .....

**Foods and Supplements For Inborn Errors Of Metabolism** (Easiphen Liquid; Loprofin Mix; Loprofin; Minaphlex; MSUD Maxamaid; MSUD Maxamum; Phlexy 10; PKU Anamix Junior IQ; PKU Lophlex IQ; PKU Anamix Infant; XP Maxamaid; XP Maxamum; XMET Maxamum)

**Initial application**

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

**Prerequisites**(tick box where appropriate)

Patient requires dietary management of inherited metabolic disorders

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)