

|                                                |                           |                               |
|------------------------------------------------|---------------------------|-------------------------------|
| <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: .....             |

**Renal Products** (Nepro; NovaSource Renal; Renilon 7.5; Suplena)

**Initial application**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

**Prerequisites**(tick box where appropriate)

The patient has acute or chronic kidney disease

**Renewal**

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

**Prerequisites**(tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

**and**  
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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)