

<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: .....

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