

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:

Preservative Free Ocular Lubricants

Initial application

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye and <input type="checkbox"/> Patient is using eye drops more than four times daily on a regular basis or <input type="checkbox"/> Patient has had a confirmed allergic reaction to preservative in eye drop
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Renewal

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

Applications from any relevant practitioner. Approvals valid for 24 months.

Prerequisites(tick box where appropriate)

The patient continues to require lubricating eye drops and has benefited from 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