

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:

Fat (Calogen; Liquigen; MCT oil (Nutricia))

Initial application — Inborn errors of metabolism

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

The patient has an inborn error of metabolism

Initial application — Indications other than inborn errors of metabolism

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

Faltering growth in an infant/child

or Bronchopulmonary dysplasia

or Fat malabsorption

or Lymphangiectasia

or Short bowel syndrome

or Infants with necrotising enterocolitis

or Biliary atresia

or For use in a ketogenic diet

or Chyle leak

or Ascites

or For use as a component in a modular formula made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceutical Schedule or breast milk

Note: Patients are required to meet any Special Authority criteria associated with all of the products used in the modular formula.

Renewal — Indications other than inborn errors of metabolism

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 1 year.

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