

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:

Naltrexone

Initial application

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence and <input type="checkbox"/> Applicant works in or with a community Alcohol and Drug Service contracted to Health NZ or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard
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Renewal

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Compliance with the medication (prescriber determined) and <input type="checkbox"/> Patient is still unstable and requires further treatment or <input type="checkbox"/> Patient achieved significant improvement but requires further treatment or <input type="checkbox"/> Patient is well controlled but requires maintenance therapy
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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