

<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: .....

**Risperidone**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

<b>or</b>	<input type="checkbox"/> The patient has had an initial Special Authority approval for paliperidone depot injection or olanzapine depot injection or aripiprazole depot injection			
	<table border="1"> <tr> <td rowspan="3" style="vertical-align: middle;"><b>and</b></td> <td><input type="checkbox"/> The patient has schizophrenia or other psychotic disorder</td> </tr> <tr> <td><input type="checkbox"/> Has not been able to adhere with treatment using oral atypical antipsychotic agents</td> </tr> <tr> <td><input type="checkbox"/> Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months</td> </tr> </table>	<b>and</b>	<input type="checkbox"/> The patient has schizophrenia or other psychotic disorder	<input type="checkbox"/> Has not been able to adhere with treatment using oral atypical antipsychotic agents
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	<input type="checkbox"/> Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months			

**Renewal**

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

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

**Prerequisites**(tick box where appropriate)

The initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of an atypical antipsychotic depot injection

**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)