Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1195**
April 2025

| **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: ..... |

## High Calorie Products (Two Cal HN; Nutrison Concentrated)

**Initial application — Cystic fibrosis**
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.
**Prerequisites**(tick boxes where appropriate)

- ☐ Cystic fibrosis

**and**

- ☐ Other lower calorie products have been tried

**and**

- ☐ Patient has substantially increased metabolic requirements

**Initial application — Indications other than cystic fibrosis**
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
**Prerequisites**(tick boxes where appropriate)

- ☐ Any condition causing malabsorption

**or**

- ☐ Faltering growth in an infant/child

**or**

- ☐ Increased nutritional requirements

**or**

- ☐ Fluid restricted

**and**

- ☐ Other lower calorie products have been tried

**and**

- ☐ Patient has substantially increased metabolic requirements or is fluid restricted

**Renewal — Cystic fibrosis**

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 3 years.
**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**

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| ..... | ..... | ..... |
| Fax Number: ..... | ..... | Fax Number: ..... |

## High Calorie Products (Two Cal HN; Nutrison Concentrated) - *continued*

**Renewal — Indications other than cystic fibrosis**

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.**

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