APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1698
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: .....

Paediatric oral/enteral feed 1 kcal/ml (Infatrini)

Initial application
Applications only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient is fluid restricted or volume intolerant and has been diagnosed with faltering growth

and

- ☐ Patient is under the care of a paediatrician or dietitian who has recommended treatment with a high energy infant formula

and

- ☐ Patient is under 18 months of age or weighs less than 8 kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

Renewal

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

Applications only from a paediatrician, dietitian or general practitioner on the recommendation of a paediatrician or dietitian. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient continues to be fluid restricted or volume intolerant and has faltering growth

and

- ☐ Patient is under the care of a hospital paediatrician or dietitian who has recommended treatment with a high energy infant formula

and

- ☐ Patient is under 18 months of age or weighs less than 8 kg

Note: 'Volume intolerant' patients are those who are unable to tolerate an adequate volume of infant formula to achieve expected growth rate. These patients should have first trialled appropriate clinical alternative treatments, such as concentrating, fortifying and adjusting the frequency of feeding.

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