

SA1859 - Standard Supplements

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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:

Standard Supplements

Initial application — Children - indications other than exclusive enteral nutrition for Crohn's disease

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

The patient is under 18 years of age

and

The patient has a condition causing malabsorption

or

The patient has failure to thrive

or

The patient has increased nutritional requirements

and

Nutrition goal has been set (eg reach a specific weight or BMI)

Renewal — Children - indications other than exclusive enteral nutrition for Crohn's disease

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

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

The patient is under 18 years of age

and

The treatment remains appropriate and the patient is benefiting from treatment

and

A nutrition goal has been set (eg reach a specific weight or BMI)

Initial application — Children - exclusive enteral nutrition for Crohn's disease

Applications only from a gastroenterologist or dietitian on the recommendation of a gastroenterologist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

The patient is under 18 years of age

and

It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease

and

Dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was 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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Standard Supplements - continued

Renewal — Children - exclusive enteral nutrition for Crohn's disease

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

Applications from any relevant practitioner on the recommendation of a gastroenterologist. Approvals valid for 3 months.

Prerequisites(tick boxes, and write the data requested in the space provided where appropriate)

The patient is under 18 years of age

and It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease

and General Practitioners and dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.....

Initial application — Adults

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

Patient is Malnourished

Patient has a body mass index (BMI) of less than 18.5 kg/m²

or Patient has unintentional weight loss greater than 10% within the last 3-6 months

or Patient has a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3-6 months

and

Patient has not responded to first-line dietary measures over a 4 week period by:

Increasing their food intake frequency (eg snacks between meals)

or Using high-energy foods (e.g. milkshakes, full fat milk, butter, cream, cheese, sugar etc)

or Using over the counter supplements (e.g. Complan)

and A nutrition goal has been set (e.g. to reach a specific weight or BMI)

I confirm the above details are correct and that in signing this form I understand I may be audited.

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Standard Supplements - continued

Renewal — Adults

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

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

Prerequisites(tick boxes where appropriate)

A nutrition goal has been set (eg reach a specific weight or BMI)

and

Patient is Malnourished

Patient has a body mass index (BMI) of less than 18.5 kg/m²

or

Patient has unintentional weight loss greater than 10% within the last 3-6 months

or

Patient has a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3-6 months

Initial application — Short-term medical condition

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

Is being fed via a nasogastric tube or a nasogastric tube is to be inserted for feeding

or

Malignancy and is considered likely to develop malnutrition as a result

or

Is undergoing a bone marrow transplant

or

Tempomandibular surgery or glossectomy

or

Pregnant

and

Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum

or

Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight

or

Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met

I confirm the above details are correct and that in signing this form I understand I may be audited.

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.....	Address:
.....
Fax Number:	Fax Number:

Standard Supplements - *continued*

Renewal — Short-term medical condition

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

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Is being fed via a nasogastric tube
or	
<input type="checkbox"/>	Malignancy and is considered likely to develop malnutrition as a result
or	
<input type="checkbox"/>	Has undergone a bone marrow transplant
or	
<input type="checkbox"/>	Tempomandibular surgery or glossectomy
or	
<input type="checkbox"/>	Pregnant
and	
<input type="checkbox"/>	Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum
or	
<input type="checkbox"/>	Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight
or	
<input type="checkbox"/>	Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met

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Standard Supplements - *continued*

Initial application — Long-term medical condition

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)
- or
- Cystic Fibrosis
- or
- Liver disease
- or
- Chronic Renal failure
- or
- Inflammatory bowel disease
- or
- Chronic obstructive pulmonary disease with hypercapnia
- or
- Short bowel syndrome
- or
- Bowel fistula
- or
- Severe chronic neurological conditions
- or
- Epidermolysis bullosa
- or
- AIDS (CD4 count < 200 cells/mm³)
- or
- Chronic pancreatitis

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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Standard Supplements - *continued*

Renewal — Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)
or	
<input type="checkbox"/>	Cystic Fibrosis
or	
<input type="checkbox"/>	Liver disease
or	
<input type="checkbox"/>	Chronic Renal failure
or	
<input type="checkbox"/>	Inflammatory bowel disease
or	
<input type="checkbox"/>	Chronic obstructive pulmonary disease with hypercapnia
or	
<input type="checkbox"/>	Short bowel syndrome
or	
<input type="checkbox"/>	Bowel fistula
or	
<input type="checkbox"/>	Severe chronic neurological conditions

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

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