

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:

Tetracycline

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

Prerequisites(tick boxes where appropriate)

☐ For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy

and

☐ For use only in combination with bismuth as part of a quadruple therapy regimen

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