

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:

Sulfadiazine

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

Prerequisites(tick boxes where appropriate)

☐ For the treatment of toxoplasmosis in patients with HIV for a period of 3 months

or

☐ For pregnant patients for the term of the pregnancy

or

☐ For infants with congenital toxoplasmosis until 12 months of age

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