Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1197
December 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 fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (KetoCal)

Initial application
Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

☐ The patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

Renewal

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

Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

☐ The patient is on a ketogenic diet and the patient is benefiting from the diet

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

Signed: ..... Date: .....
Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz