

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Propylthiouracil**

**Initial application**  
Applications from any relevant practitioner. Approvals valid for 2 years.  
**Prerequisites**(tick boxes where appropriate)

☐ The patient has hyperthyroidism

and

☐ The patient is intolerant of carbimazole or carbimazole is contraindicated

**Renewal**  
Current approval Number (if known):.....  
Applications from any relevant practitioner. Approvals valid for 2 years.  
**Prerequisites**(tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefitting from the treatment

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](mailto:customerservice@health.govt.nz)