

<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: .....

**Bee or wasp venom allergy treatment**

**Initial application**

Applications only from a relevant specialist. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

- ☐ RAST or skin test positive
- and
- ☐ Patient has had severe generalised reaction to the sensitising agent

**Renewal**

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

Applications only from a relevant specialist. Approvals valid for 2 years.

**Prerequisites**(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from 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)