

**APPLICANT** (stamp or sticker acceptable)

**PATIENT** NHI: .....

**REFERRER** Reg No: .....

Reg No: .....

First Names: .....

First Names: .....

Name: .....

Surname: .....

Surname: .....

Address: .....

DOB: .....

Address: .....

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Address: .....

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Fax Number: .....

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Fax Number: .....

**Preservative Free Ocular Lubricants**

**Initial application**

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

**Prerequisites**(tick boxes where appropriate)

☐

Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye

and

☐

Patient is using eye drops more than four times daily on a regular basis

or

☐

Patient has had a confirmed allergic reaction to preservative in eye drop

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)