

|  |                           |                               |
|--|---------------------------|-------------------------------|
| <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: .....             |

**Topical local anaesthetics** (EMLA; LMX4)

**Initial application**

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick box where appropriate)

☐ The patient is a child with a chronic medical condition requiring frequent injections or venepuncture

**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 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)