

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

High Calorie Products (Two Cal HN; Nutrison Concentrated)

Initial application — Cystic fibrosis

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites(tick boxes where appropriate)

Cystic fibrosis
and
 Other lower calorie products have been tried
and
 Patient has substantially increased metabolic requirements

Initial application — Indications other than cystic fibrosis

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

Any condition causing malabsorption
or
 Faltering growth in an infant/child
or
 Increased nutritional requirements
or
 Fluid restricted
and
 Other lower calorie products have been tried
and
 Patient has substantially increased metabolic requirements or is fluid restricted

Renewal — Cystic fibrosis

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites(tick box, and write the data requested in the space provided where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted.....

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

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

High Calorie Products (Two Cal HN; Nutrison Concentrated) - *continued*

Renewal — Indications other than cystic fibrosis

Current approval Number (if known):

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick box, and write the data requested in the space provided where appropriate)

<input type="checkbox"/> The treatment remains appropriate and the patient is benefiting from treatment and General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted

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