

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

Primaquine

Initial application

Applications only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has vivax or ovale malaria
- and
- ☐ Primaquine is to be given for a maximum of 21 days

Renewal

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

Applications only from an infectious disease specialist or clinical microbiologist. Approvals valid for 1 month.

Prerequisites(tick boxes where appropriate)

- ☐ The patient has relapsed vivax or ovale malaria
- and
- ☐ Primaquine is to be given for a maximum of 21 days

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