

**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: .....

### **Adrenaline**

#### **Initial application — anaphylaxis**

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

**Prerequisites**(tick boxes where appropriate)

or       Patient has experienced an anaphylactic reaction which has resulted in presentation to a hospital or emergency department  
 Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

and

Patient is not to be prescribed more than two devices in initial prescription

**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)