

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:

High fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (KetoCal)

Initial application

Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

☐ The patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

Renewal

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

Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years.

Prerequisites(tick box where appropriate)

☐ The patient is on a ketogenic diet and the patient is benefiting from the diet

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