

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:

Carbohydrate and Fat (Duocal Super Soluble Powder)

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)

☐ Infant or child aged four years or under
and
☐ Cystic fibrosis

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)

☐ Infant or child aged four years or under
and
☐ Cancer in children
or
☐ Faltering growth
or
☐ Bronchopulmonary dysplasia
or
☐ Premature and post premature infants

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

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)

☐ 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