

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:

Preservative Free Ocular Lubricants

Initial application

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

Prerequisites(tick boxes where appropriate)

- ☐ Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye
- and
- ☐ Patient is using eye drops more than four times daily on a regular basis
- or
- ☐ Patient has had a confirmed allergic reaction to preservative in eye drop

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