

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:

Propylthiouracil

Initial application
Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>		The patient has hyperthyroidism
and		
<input type="checkbox"/>		The patient is intolerant of carbimazole or carbimazole is contraindicated

Renewal
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient is benefitting from the treatment

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