

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:

Paediatric Products

Initial application

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Child is aged one to ten years and <input type="checkbox"/> The child is being fed via a tube or a tube is to be inserted for the purposes of feeding or <input type="checkbox"/> Any condition causing malabsorption or <input type="checkbox"/> Faltering growth in an infant/child or <input type="checkbox"/> Increased nutritional requirements or <input type="checkbox"/> The child is being transitioned from TPN or tube feeding to oral feeding

Renewal

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)

<input type="checkbox"/> 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