

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:

Vitabdeck

Initial application

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

Prerequisites(tick boxes where appropriate)

or	<input type="checkbox"/> Patient has cystic fibrosis with pancreatic insufficiency
or	<input type="checkbox"/> Patient is an infant or child with liver disease or short gut syndrome
or	<input type="checkbox"/> Patient has severe malabsorption syndrome

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