

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)

<input type="checkbox"/> Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye
and
<input type="checkbox"/> Patient is using eye drops more than four times daily on a regular basis
or
<input type="checkbox"/> 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