

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:

Rivastigmine patches

Initial application
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

The patient has been diagnosed with dementia
and
 The patient is contraindicated to or has experienced intolerable side effects from donepezil tablets

Renewal
Current approval Number (if known):.....
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

The treatment remains appropriate
and
 The patient has demonstrated a significant and sustained benefit from 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