

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT NHI:</b> .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Specialised And Elemental 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"/>	Malabsorption
or	
<input type="checkbox"/>	Short bowel syndrome
or	
<input type="checkbox"/>	Enterocutaneous fistulas
or	
<input type="checkbox"/>	Eosinophilic oesophagitis
or	
<input type="checkbox"/>	Inflammatory bowel disease
or	
<input type="checkbox"/>	Patients with multiple food allergies requiring enteral feeding

Note: Each of these products is highly specialised and would be prescribed only by an expert for a specific disorder. The alternative is hospitalisation. Elemental 028 Extra is more expensive than other products listed in this section and should only be used where the alternatives have been tried first and/or are unsuitable.

**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](mailto:customerservice@health.govt.nz)