

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:

Deferiprone

Initial application

Applications only from a haematologist. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- | |
|---|
| <p><input type="checkbox"/> The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia</p> <p>or</p> <p><input type="checkbox"/> The patient has been diagnosed with chronic iron overload due to acquired red cell aplasia</p> |
|---|

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