

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

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Fax Number: .....      Fax Number: .....

**Extensively hydrolysed formula**

**Initial application**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes, and write the data requested in the space provided where appropriate)

Cows milk formula is inappropriate due to severe intolerance or allergy to its protein content

**and**

Soy milk formula has been reasonably trialled without resolution of symptoms

**or**

Soy milk formula is considered clinically inappropriate or contraindicated

**or**

Severe malabsorption

**or**

Short bowel syndrome

**or**

Intractable diarrhoea

**or**

Biliary atresia

**or**

Cholestatic liver diseases causing malsorption

**or**

Cystic fibrosis

**or**

Proven fat malabsorption

**or**

Severe intestinal motility disorders causing significant malabsorption

**or**

Intestinal failure

**or**

For step down from Amino Acid Formula

**and**

The infant is currently receiving funded amino acid formula

**and**

The infant is to be trialled on, or transitioned to, an extensively hydrolysed formula

**and**

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted .....

Note: A reasonable trial is defined as a 2-4 week trial, or signs of an immediate IgE mediated allergic reaction.

**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)

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Name: .....	Surname: .....	Surname: .....
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.....	Address: .....	.....
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Fax Number: .....	.....	Fax Number: .....

**Extensively hydrolysed formula** - *continued*

**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 6 months.

**Prerequisites**(tick boxes, and write the data requested in the space provided where appropriate)

<input type="checkbox"/> <b>and</b> <input type="checkbox"/> <b>and</b>	An assessment as to whether the infant can be transitioned to a cows milk protein or soy infant formula has been undertaken The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted .....
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