

**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: .....

**High Calorie Products** (Two Cal HN; Nutrison Concentrated)

**Initial application — Cystic fibrosis**  
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.  
**Prerequisites**(tick boxes where appropriate)

Cystic fibrosis  
**and**  
 Other lower calorie products have been tried  
**and**  
 Patient has substantially increased metabolic requirements

**Initial application — Indications other than cystic fibrosis**  
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  
**Prerequisites**(tick boxes where appropriate)

Any condition causing malabsorption  
**or**  
 Faltering growth in an infant/child  
**or**  
 Increased nutritional requirements  
**or**  
 Fluid restricted

**and**  
 Other lower calorie products have been tried  
**and**  
 Patient has substantially increased metabolic requirements or is fluid restricted

**Renewal — Cystic fibrosis**  
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 3 years.  
**Prerequisites**(tick box, and write the data requested in the space provided where appropriate)

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)

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

**High Calorie Products** (Two Cal HN; Nutrison Concentrated) - *continued*

**Renewal — Indications other than cystic fibrosis**

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

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