

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:

Adrenaline

Initial application — anaphylaxis

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- Patient has experienced an anaphylactic reaction which has resulted in presentation to a hospital or emergency department
- or**
- Patient has been assessed to be at significant risk of anaphylaxis by a relevant practitioner

- and**
- Patient is not to be prescribed more than two devices in initial prescription

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