

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:

Fosfomycin

Initial application

Applications from any relevant practitioner. Approvals valid for 2 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli
and	
<input type="checkbox"/>	Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin
or	
<input type="checkbox"/>	The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to

Renewal

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 2 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has an acute, symptomatic, bacteriologically-proven uncomplicated urinary tract infection (UTI)/cystitis with Escherichia Coli
and	
<input type="checkbox"/>	Microbiological testing confirms the pathogen is resistant to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin
or	
<input type="checkbox"/>	The patient has a contraindication or intolerance to all of: trimethoprim, nitrofurantoin, amoxicillin, cefaclor, cefalexin, amoxicillin with clavulanic acid, and norfloxacin that the pathogen is susceptible to

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