

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:

Prednisolone sodium phosphate

Initial application

Applications only from an ophthalmologist or optometrist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has severe inflammation
- and
- ☐ Patient has a confirmed allergic reaction to preservative in eye drops

Renewal

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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