

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:

Gluten Free Foods (Bakels Gluten Free Health Bread Mix; Horleys Bread Mix; Horleys Flour; NZB Low Gluten Bread Mix; Orgran; Healtheries Simple Baking Mix)

Initial application — all patients

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

- ☐ Gluten enteropathy has been diagnosed by biopsy

or

☐ Patient suffers from dermatitis herpetiformis

Initial application — paediatric patients diagnosed by ESPGHAN criteria

Applications only from a paediatric gastroenterologist. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

- ☐ The paediatric patient fulfils ESPGHAN criteria for biopsy free diagnosis of coeliac disease

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