

APPLICANT (stamp or sticker acceptable)

PATIENT NHI:

REFERRER Reg No:

Reg No:

First Names:

First Names:

Name:

Surname:

Surname:

Address:

DOB:

Address:

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Address:

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Fax Number:

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Fax Number:

Preservative Free Ocular Lubricants

Initial application

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

Prerequisites(tick boxes where appropriate)

☐ Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye

and

☐ Patient is using eye drops more than four times daily on a regular basis

or

☐ Patient has had a confirmed allergic reaction to preservative in eye drop

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