Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1195
November 2026

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

High Calorie Products (Two Cal HN; Nutrison Concentrated)

Initial application — Cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.
Prerequisites(tick boxes where appropriate)

- ☐ Cystic fibrosis

and

- ☐ Other lower calorie products have been tried

and

- ☐ Patient has substantially increased metabolic requirements

Initial application — Indications other than cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

- ☐ Any condition causing malabsorption

or

- ☐ Faltering growth in an infant/child

or

- ☐ Increased nutritional requirements

or

- ☐ Fluid restricted

and

- ☐ Other lower calorie products have been tried

and

- ☐ Patient has substantially increased metabolic requirements or is fluid restricted

Renewal — Cystic fibrosis

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.
Prerequisites(tick box, and write the data requested in the space provided where appropriate)

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

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
.....	.....	.....

High Calorie Products (Two Cal HN; Nutrison Concentrated) - *continued*

Renewal — Indications other than cystic fibrosis

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites(tick box, and write the data requested in the space provided where appropriate)

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

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General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted .....

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