SA1859 - Standard Supplements

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APPLICANT (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

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.....

PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

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REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

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Standard Supplements

Initial application — Children - indications other than exclusive enteral nutrition for Crohn's disease
Applications from any relevant practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

- ☐ The patient is under 18 years of age

and

- ☐ The patient has a condition causing malabsorption

or

- ☐ The patient has failure to thrive

or

- ☐ The patient has increased nutritional requirements

and

- ☐ Nutrition goal has been set (eg reach a specific weight or BMI)

Renewal — Children - indications other than exclusive enteral nutrition for Crohn's disease

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

Applications from any relevant practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

- ☐ The patient is under 18 years of age

and

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

and

- ☐ A nutrition goal has been set (eg reach a specific weight or BMI)

Initial application — Children - exclusive enteral nutrition for Crohn's disease
Applications only from a gastroenterologist or dietitian on the recommendation of a gastroenterologist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient is under 18 years of age

and

- ☐ It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease

and

- ☐ Dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was 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: .....
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Address:	DOB:	Address: .....
.....	Address:	.....
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Standard Supplements *- continued*

Renewal — Children - exclusive enteral nutrition for Crohn's disease

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

Applications from any relevant practitioner on the recommendation of a gastroenterologist. Approvals valid for 3 months.

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

☐ The patient is under 18 years of age

and

☐ It is to be used as exclusive enteral nutrition for the treatment of Crohn's disease

and

General Practitioners and dietitians must include the name of the gastroenterologist recommending treatment and the date the gastroenterologist was contacted.....

Initial application — Adults

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

Patient is Malnourished

☐ Patient has a body mass index (BMI) of less than 18.5 kg/m^2

or

☐ Patient has unintentional weight loss greater than 10% within the last 3-6 months

or

☐ Patient has a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3-6 months

and

Patient has not responded to first-line dietary measures over a 4 week period by:

☐ Increasing their food intake frequency (eg snacks between meals)

or

☐ Using high-energy foods (e.g. milkshakes, full fat milk, butter, cream, cheese, sugar etc)

or

☐ Using over the counter supplements (e.g. Complan)

and

☐ A nutrition goal has been set (e.g. to reach a specific weight or BMI)

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Standard Supplements *- continued*

Renewal — Adults

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

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

Prerequisites(tick boxes where appropriate)

☐ A nutrition goal has been set (eg reach a specific weight or BMI)

and

Patient is Malnourished

☐ Patient has a body mass index (BMI) of less than 18.5 kg/m^2

or

☐ Patient has unintentional weight loss greater than 10% within the last 3-6 months

or

☐ Patient has a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3-6 months

Initial application — Short-term medical condition

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites(tick boxes where appropriate)

☐ Is being fed via a nasogastric tube or a nasogastric tube is to be inserted for feeding

or

☐ Malignancy and is considered likely to develop malnutrition as a result

or

☐ Is undergoing a bone marrow transplant

or

☐ Tempomandibular surgery or glossectomy

or

☐ Pregnant

and

☐ Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum

or

☐ Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight

or

☐ Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met

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Address:	DOB:	Address: .....
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Standard Supplements *- continued*

Renewal — Short-term medical condition

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

Applications from any relevant practitioner. Approvals valid for 1 year.
Prerequisites(tick boxes where appropriate)

- ☐ Is being fed via a nasogastric tube

or

- ☐ Malignancy and is considered likely to develop malnutrition as a result

or

- ☐ Has undergone a bone marrow transplant

or

- ☐ Tempomandibular surgery or glossectomy

or

- ☐ Pregnant

and

- ☐ Patient is in early pregnancy (< 13 weeks) and has severe clinical hyperemesis gravidarum requiring admission to hospital and is unlikely to meet her nutritional requirements due to continuing hyperemesis gravidarum

or

- ☐ Patient has clinical hyperemesis gravidarum continuing past 13 weeks and either there is concern that the patient is unlikely to meet the Institute of Medicine's (1990) recommended weight gain guidelines for pregnancy or the patient's weight has not increased past her booking/pre-pregnancy weight

or

- ☐ Patient is having multiple births and is under the care of an obstetric team who consider the nutritional needs of the patient are not being met

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Standard Supplements *- continued*

Initial application — Long-term medical condition
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)

or

- ☐ Cystic Fibrosis

or

- ☐ Liver disease

or

- ☐ Chronic Renal failure

or

- ☐ Inflammatory bowel disease

or

- ☐ Chronic obstructive pulmonary disease with hypercapnia

or

- ☐ Short bowel syndrome

or

- ☐ Bowel fistula

or

- ☐ Severe chronic neurological conditions

or

- ☐ Epidermolysis bullosa

or

- ☐ AIDS (CD4 count < 200 cells/mm^3)

or

- ☐ Chronic pancreatitis

I confirm the above details are correct and that in signing this form I understand I may be audited.

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Address:	DOB:	Address: .....
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Standard Supplements *- continued*

Renewal — Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

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

Prerequisites(tick boxes where appropriate)

- ☐ Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)

or

- ☐ Cystic Fibrosis

or

- ☐ Liver disease

or

- ☐ Chronic Renal failure

or

- ☐ Inflammatory bowel disease

or

- ☐ Chronic obstructive pulmonary disease with hypercapnia

or

- ☐ Short bowel syndrome

or

- ☐ Bowel fistula

or

- ☐ Severe chronic neurological conditions

I confirm the above details are correct and that in signing this form I understand I may be audited.

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