



CANTERBURY CHARITY HOSPITAL TRUST

"By the Community - For the Community"
'Nā te hapori, mā te hapori'

REFERRAL and DECLARATION

This is available via web site - www.charityhospital.org.nz This form can be faxed, posted or delivered.

PATIENT DETAILS

Family name _____ First name _____

NHI _____ D.O.B _____

Patient's address _____

Contact phone _____ Mobile (preferred) _____

Home _____ Work or associate _____

REFERRER'S DETAILS

Name _____

Practice / Medical Clinic _____

Phone _____ Fax _____

Specific Rx required _____

Supporting notes / xrays enclosed _____

Dental Referral - Please use alternate form.

DECLARATION

I _____ print patients name

declare that:

I cannot get specialist help for my health condition through the public health system _____ (initial)

I do not have medical insurance or access to private funds that will help pay for my treatment _____ (initial)

ACC will not cover payment for any part of my treatment _____ (initial)

I have NO funds available to pay for private treatment _____ (initial)

I understand that this FREE service is run by volunteer staff and funded by public donations and grants. I accept that failure to attend for appointments or late cancellation could result in the offer of treatment being withdrawn. _____ (initial)

Signed (Patient) _____ Date _____

Signed (Referrer) _____

Name of Referrer _____ Practice / Organisation _____