



**CANTERBURY
CHARITY HOSPITAL
TRUST**

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

DENTAL 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 _____

 Mobile phone _____ Home phone _____
 Next of kin _____ Phone number _____

REFERRING DENTIST DETAILS

Name _____
 Practice / Dental Clinic _____
 Phone _____ Fax _____
 Specific Rx required _____

 Supporting notes / xrays enclosed

Referring dentists - please only refer patients who can complete the application in full. Further information, regarding types of Rx available, can be sourced from our website www.charityhospital.org.nz

DECLARATION

I _____ print patients name
 declare that:
 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 am a WINZ beneficiary and have exhausted all WINZ grants and loans _____ (initial)
 Type of Benefit received (essential) _____ (initial)
 I am not in paid employment for more than 16 hours per week _____ (initial)
 I understand that this FREE service is run by volunteer staff and I accept that failure to attend for appointments or late cancellation will result in the offer of treatment being withdrawn. _____ (initial)
 Signed (patient) _____ Date _____
 Signed (Referring Dentist) _____
 Name of Dentist _____ Dental Practice _____