CANTERBURY
CHARITY HOSPITAL
TRUST

By the Community – For the Community
Nā te hapori, mā te hapori

DENTAL REFERRAL and DECLARATION

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

PATIENT DETAILS

Family name _____ First name _____

D.O.B _____ ☐ Female ☐ Male

Patient's address _____

_____

Mobile phone _____ Email address _____

Next of kin _____ Phone number _____

REFERRING DENTIST DETAILS

Name _____

Practice / Dental Clinic _____

Phone _____

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and I accept that failure to attend for appointments or late cancellation will result in the offer of treatment being withdrawn.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 _____

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