Southland Charity Hospital

REFERRAL and DECLARATION

This form is available via website - southlandcharityhospital.org/forms | Please email form to referrals@southlandcharityhospital.org

Patient Details

Family Name _____ First name(s) _____

NHI _____ D.O.B. _____

Patient's address _____

_____

Contact phone _____ Mobile (preferred) _____

Home _____ Work or associate _____

Referrer's Details

Name _____

Practice/MedicalClinic _____ Phone _____

Specific RX required _____

Supporting notes / xrays enclosed _____

_____

Dental Referral - Please use alternate form

Declaration

I _____ *Print patient's 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 I accept that failure to attend for appointments or late cancellation could result in the offer of treatment being withdrawn.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)* _____ Date _____

Name of referrer _____ Practice / Organisation _____

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