Southern Charity Hospital

REFERRAL and DECLARATION FORM

This form is available via ERMS and online at **www.sch.nz**

Please use ERMS to send Referral Form to SCH Clinical Manager

If you have any questions please contact the Clinical Manager at **referrals@sch.nz** or **027 3200 168**

Patient Details

Family Name

First name(s)

NHI

D.O.B.

Patients Address

Contact phone

Other Phone

Email

Referrer's Details

Name

Email

Practice/Medical Clinic

Phone

Specific RX required

Supporting notes/xrays provided

Declaration

I *Patient Name*

Declare that:

I cannot get specialist help for my health condition through the public 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 the public *(Initial)*

Signed *(patient)*

Date

Signed *(referrer)*

Date

Name of referrer

Practice/Medical Clinic

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