Southern Charity Hospital

DENTAL REFERRAL and DECLARATION

PATIENT DETAILS

Family name _____ First name _____

NHI _____ D.O.B _____

Patient's address _____

_____

Contact phone _____ Mobile (preferred)

Home _____ Work or associate _____

REFERRING DENTIST

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.sch.nz

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 am a WINZ beneficiary and have exhausted all WINZ grants and loans _____ (initial)

WINZ Beneficiary Number (essential) _____ _____ (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and I accept that failure to attend for appointments or late cancellation will result in the offer of treatment being withdrawn.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 _____

99 Wicklow Street, Clifton, Invercargill 9812
Email: referrals@sch.nz Website www.sch.nz

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