REFERRAL FORM

PATIENT'S DETAILS (Note: patient must be NZ permanent resident / NZ Citizen)

Family Name____

First Name _________________________________

NHI ____ DOB ______________________________________
Address
____
____
____

Contact Phone ____ home * (*essential) Numbers

____ mobile
____ email

HEALTH PROFESSIONAL'S DETAILS

Name ____

Medical Centre
____ Phone
____ Fax ____
Email
____

REFERRAL DETAILS

Request treatment
for____

CHECKLIST:

- Health Professional Referral letter attached,
- Patient assessment filled out as per website,
- Declination letter from DHB attached

The completed referral and accompanying correspondence can be

posted to : P O Box 301 314, Albany, Auckland, 0752

or emailed to: info@aucklandcharityhospital.org