ARCH
AUCKLAND REGIONAL CHARITY HOSPITAL

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: PO Box 31699, Milford, Auckland, 0741

or emailed to: info@aucklandcharityhospital.org