# ACCOMMODATION REQUEST FORM

Ph: 03 377 2515

Please complete this form, scan and email to info@bmct.org.nz

Name of Referrer _____ Medical Facility _____ Ward _____

## Patient information

If this application relates to a High Risk Pregnancy the patient will be the pregnant mother and a clinician's letter of confirmation will be required.

First Name:

Surname:

Date of Birth: ☐ Male ☐ Female

MOH Number*:

*Registration for accommodation subsidies under the National Travel Assistance Policy

NHI Number:

New or Returning Family?:

Ethnicity:

Date of Arrival:

Expected Date of Departure:

## Diagnosis

- ☐ Antenatal
- ☐ Auto Immune
- ☐ Burns
- ☐ Cardiac
- ☐ Hematology
- ☐ ENT
- ☐ Gastro
- ☐ Liver/Kidney
- ☐ MRI/X-Rays
- ☐ Other (please specify)
- ☐ Neurological
- ☐ Neonatal
- ☐ Mental Health
- ☐ Medical
- ☐ Oncology
- ☐ Opthalmology
- ☐ Orthopaedic
- ☐ Womens
- ☐ Respiratory
- ☐ Surgical

## Family contact details

Address:

Suburb:

City: Postcode:

Phone (home):

Phone (mob):

Email:

## Emergency contact details

This must be someone who is NOT staying at Ranui House

First Name:

Surname:

Relationship:

Phone (home):

Phone (mob):

Email:

## Accommodation requirements

### Adults

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

### Children

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female

First Name:

Surname:

Relationship to Patient:

Date of Birth: ☐ Male ☐ Female