Community Surgery Referral Form

The Braemar Charitable Trust (the Trust) will consider funding elective health procedures under its Community Surgery Programme where:

1. A patient meets the Braemar Charitable Trust Community Surgery Criteria. The Trust will pay the operative and in hospital costs of the procedure when performed at Braemar Hospital;
2. An uninsured person has an unexpected return to theatre, the Trust will pay the theatre costs of the return but not the surgeons or anaesthetists fees (if any);
3. An uninsured person or ACC patient, who has been a patient of Braemar Hospital is unexpectedly required to be re-admitted to Braemar Hospital as a consequence of the previous admission. The Trust will pay the costs of that re-admission, but not the surgeons or anaesthetists fees (if any).

The decision whether a patient is eligible to receive a free elective procedure under the Braemar Community Surgery Programme, will be determined by the Trust and is subject to available funds. Referrer's must complete all parts of this form, sign and return it to the Trust Manager, Braemar Charitable Trust email: paulab@braemartrust.co.nz or by post to Braemar Charitable Trust, PO Box 972, Waikato Mail Centre 3240.

All information provided is collected and used in accordance with the Privacy Act 2020, Health Information Privacy Code 2020 and the "Braemar Charitable Trust Privacy Statement" as set out at in this referral form

Referrer to Complete:

Surgeon Name:	
Anaesthetist Name:	
Proposed procedure:	
Estimated time in Theatre (for surgeon completion only):	
Are both the Surgeon and Anaesthetist providing their services free of charge?	Yes/No
Patient NHI:	
Please confirm and verify that your patient meets all of the following criteria and conditions. Does your patient:	
Live within the Midlands Region?	Yes/No
Have Medical Insurance?	Yes/No
Have ACC cover (including either elective surgery or treatment injury provisions)?	Yes/No
Have any chance of having their procedure performed at a public hospital within a reasonable timeframe?	Yes/No
In your opinion, have the financial means to pay for this procedure?	Yes/No
It would be appreciated if you could ask your patient whether they would like to contribute to the cost of their procedure and if so, how much they would like to contribute. Thank you	Contribution Offered $

Please provide the following information (you can attach in a separate letter if you wish): • A brief outline as to why your patient should be considered for assistance through the Community Surgery Programme • A summary of your patient's condition and proposed procedure, including the patient's medical notes and if relevant, any photos of external skin lesions or conditions requiring surgical intervention • Any special Considerations (Equipment, special care etc):	

I have completed all sections of the application form and have provided information outlining why my patient should be considered as part of the Braemar Community Surgery Programme.

Signed (Referrer): **Date:**

Prior to submitting the Community Surgery referral please check that all sections of the request form have been completed and signed by both Referrer and Patient. Photos of any external skin lesions or conditions requiring surgical intervention have been included.

Application for Assistance form the Braemar Community Surgery Programme

As a Charitable Trust, we support people in clinical need who have no or limited financial means. Funding for your treatment is provided through Surgeons and Anaesthetists donating their time and services, through organisations making generous charitable donations and from the charitable funds held by the Trust. As the Trust has to cover consumables, drugs, and surgical items , we do ask that patients consider making a donation to help us- if you can do that, these funds can be used to assist another community surgery recipient. Help can be provided in completing this form by contacting Paula Baker, Trust Manager at paulab@braemartrust.co.nz Please note, the information you provide will not be given to any third party.

Patient to Complete:

Family Name:	
First Names:	
Address:	
Date of Birth:	
Email Address:	
Phone numbers: Mobile Home Work	
Do you have a Community Services Card? If yes, Card Number:	Yes/No
Do you receive a WINZ benefit (excluding pension)? If yes, state type and number:	Yes/No
Do you have any dependents? If yes, how many Children do you have: How many other dependants do you have:	Yes/No
Are you in paid employment? If yes, how many hours a week	Yes/No
What is your occupation?	
Is one member of your household a New Zealand Citizen or permanent resident?	Yes/No
Do you have the financial means to pay for your full procedure or do you have access to private funds that would pay for your full procedure?	Yes/No
Would you be willing to contribute to some of the cost of your procedure? If so, please let us know how much you would like to contribute.	Yes/No If you answered yes, how much $

Patient Declaration:

I (**Patient to print full name**)

Declare that:

- I have little chance of having my procedure performed at a public hospital within a reasonable timeframe and my condition is impacting on my quality of life
- I do not have medical insurance nor access to private funds that will help pay for my procedure
- ACC will not cover payment for any part of my treatment (including either elective surgery or treatment injury provisions)
- I do not have the financial means to pay for private treatment

I understand that funding support for my procedure is being provided by the Braemar Charitable Trust, who support people in clinical need who have no or limited financial means.

Signed (Patient): **Date:**

Braemar Charitable Trust ("BCT") Privacy Statement

1. This Privacy Statement explains how the Trust uses information you give to us, and the way we protect your privacy under the Privacy Act 2020 and the Health Information Privacy Code 2020.

Security

2. Protecting your personal information is of the utmost importance to us. The Trust have security measures in place to protect the loss and alteration of information under our control.

Personal information

3. If it is practical to do so, we will collect your information directly from you. This may take place when you complete the "Community Surgery Referral Form" for the Trust, through your Surgeon, General Practitioner or Dentist.
4. We do not collect personal information unless you choose to give it to us.
5. Information provided will be held by the Trust.

Use and disclosure

6. We only use the personal information that you provide to us on this form for the purposes for which you supplied it. We do not share your personal information externally unless this is necessary for the purpose for which you gave us the information (for instance to another treating service or hospital) or sharing is required by law.
7. We cannot use your personal information for direct marketing purposes unless you provide authorisation.

Your rights and choices

8. We are happy to provide you with access to any personal information that we hold about you. If it is incorrect, please ask us to amend it. To ask for access, correction or to ask for explanations of what we do with your information, please contact Paula Baker at: paulab@braemartrust.co.nz or by post to Braemar Charitable Trust, PO Box 972, Waikato Mail Centre 3240.