

Practice Name .....

Practice Fax No for receipt return .....

**RECEIPT OF REFERRAL**  
**For GP Practices**

**Capital & Coast DHB acknowledges receipt of referral for:-**

NHI	Name	Dept referred	No of pages	✓

**Date received by C&C DHB**

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**C&C DHB Outpatients Booking Centre**

**Fax 04 3855402**