Waitemata
District Health Board

Te Wai Awhina

First Name: _____ Gender: _____

Surname: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Ward/Clinic: Consultant:

REFERRAL

DATE SENT: ____/____/____ **DATE REC:** ____/____/____

FAX No: _____ **No of Pages:** _____

REFERRED TO: _____

Service/Ward Clinician Name (print)

REFERRED BY: _____

Service/Ward Clinician Name (print)

_____

Clinician Designation Signature ext/locator

URGENCY

☐ Immediate- now ☐ Urgent-today ☐ Within 24 hrs ☐ Within 7 days

☐ Within 1 month ☐ Non-Urgent ☐ Early Discharge

ACTIVE ISSUES

1 _____

2 _____

3 _____

4 _____

5 _____

ETHNICITY

☐ NZ European ☐ Maori

☐ Samoan ☐ Cook Island Maori

☐ Tongan ☐ Niuean

☐ Chinese ☐ Indian ☐ Other

ALERTS/ALLERGIES

☐ MRSA/ESBL and other multiresistant orgs

☐ Allergies-send ALERTS form

☐ Other – send ALERTS form

INTERPRETOR REQ:

☐ Yes ☐ No

MOBILITY

☐ Walk ☐ Chair

☐ Trolley ☐ Ambulance

REASON FOR REFERRAL

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Referral