



- Phone: External - 07 839 8943, Internal - 2211
- Fax: External - 07 839 8817, Internal - 8817

Patient sticker may be used

Preferred Title: Mr Mrs Miss Ms

NHI

Surname

DOB

Given Names

Ethnicity:
Please State

Address (Postal and residential):

Phone

Home

Work

Mobile

Phone:

Discharge Address (if different from above)

GP (Name + Practice of Usual GP)

Consultant

Community Services Card Yes No

Result of an Accident Yes No

ACC/Insurer Number

Referral Source: GP Self Community:

Hospital: _____ Ward: _____

Communication requirements:

Cultural interpreter requirements:

Maori assessor preferred:

Alerts: (i.e. Hazards at visiting address, Special Needs of Patient)

Patient's Preferred Contact Person:

Name:

Address:

Relationship:

Phone: Home

Work

Mobile

Diagnosis and Disability Needs:

Relevant Previous History:

* Reason for Referral - Please include change in need or level of function. (Add additional sheet if required):

Service Requested (see back of form for service options)

- Ward 58
- THHS
- Assessment & Outpatient Team
- Rehabilitation Clinic
- DSL Assessment
- Geriatrician/Rehabilitation Physician Consultation
- Matariki/Rhoda Read Hospital
- Transitional Care
- Clinical Nurse Specialist Consultation
- Thames Rehabilitation

Referrals sent to other services/date:

District Nurse

Physio

Social Worker

OT

Dietitian

Other

For office use only
Forwarded to (tick)

Referral Outcome

Thames

DSL

Waikato Hospital

Client consents to this Referral Yes No

Referred by: _____

Designation: _____

Contact No: _____

Signature: _____

Date: _____

*Referrals which do not contain relevant information will be returned to referrer.
The information contained in the form will assist with prioritization.
This form is to be filed in the Patient Clinical Record under Correspondence.

