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CONFIDENTIAL REFERRAL TO A PUBLIC HEALTH NURSE

		NHI:
CLIENT DETAILS		
Surname:	First Name:	
Date of Birth:	Known As:	
Address:		
Ethnicity: Maori / Pacific Island / Other	Gender:	M: <input type="checkbox"/> F: <input type="checkbox"/>
ECC / School:	Teacher:	
Year:	Room:	
Family Doctor:		

CAREGIVER DETAILS	CAREGIVER DETAILS
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Home Phone:	Home Phone:
Mobile: Phone:	Mobile: Phone:

HEALTH OR SAFETY ISSUES		
PRIORITY:		
Routine	Semi-Urgent	Urgent

REFERRER DETAILS	CLIENT/CAREGIVER CONSENT
Name:	Name:
Organisation:	Signature:
Address:	
Phone:	
DATE:	DATE:

For Public Health Use Only:

Date Referral Received:	Assigned To:	Date Assigned:
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Referral Source:	CY	DE	EC	GP	ES	HO	OTH
	PC	PH	SC	SF	VH	WC	

Referral Reason:	ALL	AIHP	BEH	CAB	DIHP	PIHP	EIHP	FV	HAS	HC
	IP	OTH	PAR	PHCM	PHH	PPP	SCH	SF	VH	

Discharge Date:	Code:	D	M	O	R	N	F	X
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