NMDHB DISTRICT NURSING / ONCOLOGY NURSING REFERRAL FORM

Nelson Marlborough District Health Board

ACC:	ACC Number:	(Place Patient Label here or write in the details)
	Date of Injury:	Surname: NHI number:
Does the injury require District Nursing Service to manage? *Examples may include: complex wounds requiring specialized wound care products, complex assessment; Doppler assessment; compression therapy; IV therapy, paraplegic / tetraplegic related, etc*		First Names: GP: Address: D.O.B. Telephone:
No: Refer patient to GP / Practice Nurse		**DATE OF REFERRAL:**
Yes: Refer to District Nursing Service – COMPLETE THIS FORM.		**REFERRED BY:**
Circle the appropriate code below:		**DATE OF DISCHARGE/SEEN BY REFERRER:**
M Motor Vehicle Accident	W Employed Work Related	**DATE OF FIRST VISIT:**
E Employed Not Work Related	U Not Employed	**PATIENT'S TELEPHONE NUMBER:**

INDICATE WHICH DISTRICT NURSING SERVICE/S REQUIRED

District Nurses		IV Therapy		Continence assessment (please complete Continence referral)	
CAPD Resource Nurse		Oncology Nurses		Catheter (please complete D/N referral **AND** Catheter referral forms)	
CPAP		Stoma		Oxygen (Specialist to complete Oxygen prescription form as well)	
Enteral Feeding				Wound Care Specialty Clinical Nurse	

OTHER SERVICES INVOLVED (NB: this referral does not cover these services – complete appropriate form for appropriate service)

Dietician		Occupational Therapy		Physiotherapy		Smoking Cessation	
Health Educator		Orthotics		Pukenga Hauora		Speech Therapy	
Meals on Wheels		Pharmacy		Other (indicate)			

ALERTS		Details:			Details:
Infectious	Y / N		AMR	Y / N	
Dog at house	Y / N		Lives alone	Y / N	

GENDER: M / F	**ETHNICITY:**	**NZ RESIDENT:** Y / N	***If no, has the pt got medical insurance?*** Y / N

ADDRESS TO VISIT ON DISCHARGE:
(Only if different to patient label /details or Fire No./directions if a Rural Delivery address)

FAMILY / WHANAU / CAREGIVER:

RELATIONSHIP: **TELEPHONE:**

DIAGNOSIS / SURGERY & DATE:

RELEVANT HISTORY:

TREATMENT REQUIRED: (Include type of sutures, ROS date, any other information which may affect the care required, etc)

CURRENT MEDICATIONS ON DISCHARGE:

ALLERGIES / SENSITIVITIES:
(this section must be completed)

DATE: ____________ **PRINT NAME AND AREA OF REFERRER:** ____________

SIGNATURE: **DESIGNATION:**

FAX THIS REFERRAL TO:

MARLBOROUGH
DISTRICT NURSING: 03 5209906 (internal – 6906)
ONCOLOGY NURSING: 03 5776987

NELSON
DISTRICT NURSING: 03 5461602 (internal – 7602)
ONCOLOGY NURSING: 03 5463917 (internal – 3917)

GOLDEN BAY
03 5256293 (internal – 7109)

MOTUEKA
03 5281166 (internal – 7166)

MURCHISON
035231121 (internal – 7121)