



Physiotherapy Occupational Therapy Dietitian Social Worker Speech Language

NZ Resident: Yes: No: ACC Yes: No:

Date: ___/___/___ Hospital number: _____ ACC Claim number: _____

DETAILS:

Mr / Mrs / Miss/ Ms Other: _____ Surname: _____ First Name: _____

Address: _____ D.O.B: ___/___/___

Phone number: _____ Email: _____

GP: _____ Client Consent: Yes No

NoK / Local Contact: Name: _____ Phone: _____ Relationship: _____

ETHNICITY:

New Zealand European Maori Samoan Tongan

Cook Island Maori Niuean Chinese Indian

Other (e.g. Dutch, Japanese, British) please state: _____

DIAGNOSIS / CLINICAL INFORMATION / DISABILITY:

REASON FOR REFERRAL / PRESENTING SYMPTOMS (please provide as much detail as possible):

Please describe the urgency / reason: Low Medium High R.Q.F.V: Yes(+) (-) No

Reason: _____

PAST MEDICAL HISTORY:

SOCIAL SITUATION: Lives Alone: Family: Others: Details: _____

MEDICATIONS: _____

ANY SAFETY ISSUES / RISKS TO ASSESSOR OR CLIENT: _____

TRANSPORT:

Own: Carer: Required:

OTHER HEALTH PROFESSIONALS / AGENCIES INVOLVED: _____

SUPPORT SERVICE PROVIDER (CONTACT NAME): _____

IS THE CLIENT KNOWN TO PUKENGA HAUORA: Yes No _____

ADDITIONAL INFORMATION REQUIRED FOR A DIETITIAN REFERRAL:

Current Weight: _____ Current Height: _____ BMI: _____ Recent Weight Changes: _____

REFERRER'S DETAILS:

Name: _____ Phone: _____ Email: _____

Designation: _____

OFFICE USE ONLY: Client Name: _____ NHI: _____
Acceptance into Allied Health: Yes: No: Discipline Action
Funder ACC: 34: 35: Dept Code: A01: D01: D41: Clinics A01: ATR OPT: ATRComm:
Triage: Urgent: Semi - Urgent: Routine: Therapist Assigned: _____

Internal Referral Request: Service Requested OT: PT: SLT: SW: DIET:
Signed: _____ Date: ___/___/___ Client Consent: Yes: No:

Nelson Fax (03) 546-1597
Wairau Fax (03) 520-9906