

PUBLIC HEALTH SERVICE REFERRAL FORM

Phone (06) 350 4560 • Email <u>schoolhlth@midcentraldhb.govt.nz</u> Please note: If a referral is received after 12 midday, it will not be followed up until the following day, Monday to Friday, unless indicated.

Family name:		First name:		
Address;		Town/City:		
			-	Mala Fazzala Azathari
Date of Birth:		Gender	(fiCk):	
Family doctor & practice name:				Ethnicity:
School:				Room:
Parent/Caregiver:				Parent/Caregiver email:
Relationship to child/young person:				
Contact no's: Cell:	Home:			Work:
Client/Parent/Caregiver made aware of re	ferral: Yes	No	Dat	te of consent to refer:
Behavioural concern Breathing concern Concentration Contraception assessment request Diagnosed allergy Dietary issue Discharge from ears Health education session Hearing problem (attach ENROL report) Medical / Medication advice Quit smoking request Source / Medication advice Solling Sores / Itchy skin or head Speech development concern Suspected abuse / Neglect / Violence Vision problems (attach ENROL report) Vomiting / Diarrhoea Wetting Other: Presenting concern (brief description of the problem):				
Referrer's Name:	Designation:			Key contact for child at school:
Signed (School/Provider):	Date/Time:			
FOR PHN USE ONLY: Client/Parent/Caregiver agree/disagree that information can be shared with the school (please circle). Public Health Nurse signature				
FOR OFFICE USE ONLY:				
Time received: Date received: Signature				
PHN contacted (name):		Date:		
Key Worker open:		C01.02/C	03.05	6/4660/R259/SH01.03 Check for existing file.
PRIVACY INFORMATION: Information from this form will be stored in note form and on a computer and may be used for onward referral purposes. Consumers have the right to view any information MidCentral DHB holds.				