WHAKAWATEATIA
HAWKE'S BAY
District Health Board

Fill in only if patient label is unavailable

Name: ..... DoB: .....

NHI: ..... Phone: .....

Address: .....

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Referral for Ongoing Community Care

☐ Occupational Therapy	Fax: 06 878 1310 Duty Page: 3147	☐ Diabetes Service *Attach drug chart and blood glucose records*	Fax: 06 873 2169 Int. 2269
☐ Physiotherapy	Fax: 06 878 1310 Duty Page: 3351	☐ Maori Health Service *Kaitakawaenga*	Fax: 06 878 1655 Int. 5781
☐ Social Workers	Fax: 878 1310		
***Internal fax for above services is 2210**		☐ CHB Community Services	Fax: 06 858 7200
☐ Speech Language Therapy	Fax: 06 878 1380 Int: 2966	☐ Wairoa Community	Fax: 06 838 9712

Wairoa/CHB indicate discipline/s requested: .....

Discharge Date: anticipated / confirmed: .....

Other Contact Name: ..... Ph No.: .....

Relationship to Patient: .....

GP: ..... Ph No.: .....

Ethnic Group (choose up to three):

☐ NZ European	☐ Maori	☐ Cook Island Maori	☐ Indian
☐ Nuiean	☐ Samoan	☐ Tongan	☐ Chinese

☐ Other: *(such as Dutch, Japanese, Tokelauan):* .....

Accident? ☐ Yes ☐ No Date of Accident: ..... ACC No.: .....

Diagnosis (include prognosis where applicable): .....

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Is the patient aware of the diagnosis? ☐ Yes ☐ No Is patient aware of the referral? ☐ Yes ☐ No

Other outpatient appointments (state days/time)? .....

Current Functional Status:

Mental Condition	**Mobility**	**Communication Barriers**
☐ Alert	☐ Dependent	☐ Vision problems
☐ Confused	☐ Independent	☐ Hearing problems
☐ Unresponsive	☐ Type of aid	☐ Aphasia/dysarthria
☐ MMSE	☐ Wheelchair dependent	☐ English not first language
☐ Other	☐ Confined to bed	☐ Interpreter service required
	☐ Weight	

Skin Integrity	**Medications**	**Continence**
☐ Waterlow Scale	☐ No medication	Problems? ☐ Yes ☐ No
☐ Intact / healthy	☐ Able to self administer	
☐ Intact / frail	☐ Requires supervision	
☐ Broken areas	☐ Blister pack	
☐ Pressure injury		
☐ Rashes		

☐ Sensitivities .....

☐ Allergies .....

REFERRAL FOR ONGOING COMMUNITY CARE

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Name: ..... DoB: .....

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Reason for Referral (include issues to be addressed, goals to be achieved and level of urgency) be specific:

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Reason for Hospitalisation / Treatment / Therapy Given: .....

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Social Situation: .....

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Functional performance problems i.e. transfer issues, falls, ADLs etc: .....

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Name of Referrer: ..... Designation: .....

Signature: ..... Date: ..... Time: .....

Phone (ext no.): .....

Administration Use Only

Date Received: ..... OT PT SLT SW Ref Code: .....

Contract Code: ..... Allocated To: .....

Priority: 1 2 3 4 Prioritised By: .....