BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

ALLIED HEALTH SERVICES REFERRAL FORM

Eastern Bay of Plenty

Surname…… **First name**…… **Title**……..

NHI: …….. **D.O.B.** …… **G.P/Consultant**……

Residential Address …… **Cell/ Phone**……

Address on Discharge …… **Cell/Phone**……

Preferred contact person:…… **Relationship** ……

Address of contact: …… **Cell/Phone**……..

Social Situation: ……

Alerts/Precautions when visiting (dogs, safety etc) ……

Present Diagnosis/Health Status: ……

Relevant Health History: ……

If inpatient: **Ward/Hospital**: …….. **Phone/ext**……

Anticipated Date of Discharge: …… **Date first visit required**: ……..

SERVICES:	Involved	Required	Reason for Referral or Comments:
Occupational Therapist	☐	☐	
Community Physiotherapist	☐	☐	
Speech Language Therapist	☐	☐	
Social Worker	☐	☐	
Post Discharge Home Support	☐	☐	
Dietitian	☐	Use referral forms specific to these services	
Support Net	☐		
Palliative Care Services	☐		
District & Oncology Nurses	☐		

Allied Health Intervention to be funded by:

DHB ☐ **Private** ☐ **ACC** ☐ **Claim No**…… **Other** ☐ ……

Referred by: ……**Place/Dept**……**Phone**: ……**Date**: ……
PRINT

PLEASE either FAX to *(07) 306 0702*
or POST to *Eastern Bay of Plenty Referrals c/- Te Koru Therapy and Rehab, P.O. Box 241, Whakatane 3158*

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Office use only

Date received: …….. *Date Entered:* …… *Initial*……..

Does the patient have an Allied Health File No Yes

Previous Occ Ther …….. *Date last seen:*…….. *Open/Discharged*

Previous Physio …… . *Date last seen:*…….. *Open/Discharged*

Previous SLT …….. *Date last seen:* …….. *Open/Discharged*

Previous S/wker …… *Date last seen:* …….. *Open/Discharged*

This referral will be allocated to: ……..