BAYNAV 1010 8/23

Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

Patient Name: _____

Address: _____

Phone: _____ DOB: _____ Age: _____

☐ Male ☐ Female NHI: _____

REQUEST FOR DISTRICT NURSING SERVICES

Bay of Plenty Community Care Coordination

Telephone: 0800 BOP CCC (267 222)
Email: admin@bopccc.org.nz

Please attach supporting documentation to your DN referral

Resident of NZ? ☐ Yes ☐ No Ethnicity: _____

GP Practice Name: _____ GP Name: _____

Emergency contact name: _____ Emergency contact phone: _____

Date of discharge: _____ Date 1st DN visit required: _____

Temporary discharge address: _____

IS THIS AN ACC PATIENT? ☐ **YES** ☐ **NO**

If YES, please complete the following information … (leave blank if non-accident)

Date of injury _____ **ACC claim number** _____

SOCIAL FACTORS / HOME CIRCUMSTANCES

Lives alone ☐ Yes ☐ No Spouse / Partner: ☐ Yes ☐ No

Potential risks/alerts visiting the home (eg. access, dog etc) ☐ Yes ☐ No ☐ Don't know

If YES, please specify _____

Patient's main activity (paid work, study, caregiving)

_____

Is patient able to attend clinic? ☐ Yes ☐ No

If unable to attend clinic give reason _____

CURRENT CLINICAL DETAILS (SURGICAL INFORMATION)

ALLERGIES IDENTIFIED ☐ Yes ☐ No

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REQUEST FOR DISTRICT NURSING SERVICES

SPECIFIC NURSING REQUIREMENTS

Presenting Problem List

- ☐ Accident or injury
- ☐ Complex wounds
- ☐ Continence Issues
- ☐ Oncology
- ☐ Ostomy
- ☐ Oxygen Therapy
- ☐ Post-surgical condition
- ☐ Rheumatic fever
- ☐ Simple wounds

Service Type

- ☐ General Community Nursing
- ☐ OPIVA (previously known as HiTH)

REFERRAL REASON

Supporting documentation required:

☐ Wound Care Plan ☐ Drain Chart ☐ Community Out-Patient Medication Chart

RELEVANT PAST MEDICAL HISTORY

REFERRER DETAILS

REFERRED BY: _____

Full name Designation

_____

Ward /service Phone Date

PRINT FORM OUTLOOK MUST BE OPEN to CLICK HERE TO SUBMIT CLEAR FORM