BAYNAV 1012 10/23

PAEDIATRIC CHRONIC DISORDERS GROUP REFERRAL

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

NHI: _____ **D.O.B:** _____

Last Name: _____ **First Name:** _____ **Address:** _____

Phone: _____ **Date of Referral:** _____

Referred by *(Name)*: _____ **Designation:** _____ **Contact number:** _____

Ethnicity: ☐ New Zealand European Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan
☐ Niuean ☐ Chinese ☐ Indian
☐ Other (please state): *(e.g. Dutch, Japanese, Tokelaunan)* _____

Interpreter Required? ☐ Yes ☐ No

Parent/Caregiver Name: _____

REASON FOR REFERRAL AND RELEVANT MEDICAL HISTORY

☐ Pain ☐ Chronic Fatigue ☐ Long Covid ☐ Dysfunctional Breathing ☐ POTS
☐ Functional Neurological Disorder (FND)

GOALS OF FAMILY

Is family aware of Referral and group settings? ☐ Yes ☐ No

OTHER SERVICES INVOLVED

☐ CDS
☐ CAMHS
☐ MOE
☐ Gender Dynamix
☐ Community Services
☐ Northern Health School

Clinician involved: _____ Next paediatric review: _____

Referrer: _____ Signature: _____

Department: _____ Referral date: _____

Contact number: _____ Email: _____

☐ **All medical investigations completed** (this must be ticked)

PRINT FORM **OUTLOOK MUST BE OPEN when you click here to submit** **CLEAR FORM**