REFERRAL FORM
Kaupapa District Nursing Service
Regional Māori Health Service
Tauranga Hospital

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Please fax referral to 07 571 2397

Date of Referral _______________ Referrer Name: ______________________________

Ward/Department: _________________ Signature: __________________________________

Insert Patient Label or Patient Details

NHI: _______________ DOB: ___________________

ADDRESS:

_________________________________ Phone: ____________________________

_________________________________ Cell: ______________________________

_________________________________ Hauora/GP _________________________

Any potental risks / alerts in visiting home e.g access, dog etc ☐ Yes ☐ No ☐ Don't Know
If YES, please specify

Ethnicity: ☐ NZ Māori ☐ Non Māori ☐ Other please state _______________________
Iwi: please state_________________________

Services Required: (Please tick applicable boxes)

☐ Home Help ☐ Personal Cares ☐Education

☐Chronic or Complex Wounds ☐ Continence/Bowel Care ☐Catheter Insertion

☐ HITH Care ☐ Rheumatic Fever ☐ Surgical

☐ Paediatric Surgical ☐ Paediatric Medical ☐ Other

please state other ________________

DESCRIBE NEEDS ..

"Healthy, Thriving Communities - Kia momoho te hapori oranga"
Regional Māori Health Services, Private Bag12024, Tauranga 3143
Phone: 579 8560 Fax: 07 571 2397
Email: maori.health@bopdhb.govt.nz

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Urgency: ☐ 24 hours ☐ 48 Hours ☐ 1 Week ☐ **Referral Mainstream DN if weekend or public holiday Refer back to Māori Health next working day.**

Clutural Details

Te Reo / Languagerequirements:

Whanāu / FamilySupport requirements:

Māori Rongoa / Māori Medicines

Māori Therapies

Social Factors / Home Circumstances

Lives Alone Yes ☐ No ☐ Family Member Spouse ☐ Son/Daugher ☐ Other ☐

Please state other (i.e neighbour/friend) ___________________________

Name of Person ________________________________

Phone: ____

Exisiting Service/s ________________________________ Hours per Week _____________

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Allergies Identified ___________________________________

Relevant Past Medical History