Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Rural and Community
Nursing Referral Form

Community Referral Centre (CRC),
Fax to: Ext 22071 or 07 858 1071

Patient Label

Name: _____

NHI: _____ DOB: _____ dd/mm/yy

Address: _____

Patient is aware of referral? ☐ Yes ☐ No

Discharge address and phone contact (if different to above) Patient's current phone number:	**Patient's preferred contact person** Name: Address: Relationship: Phone: Day Mobile

ACC	**Risk factors**
ACC number _____ Work related? ☐ Yes ☐ No Date of injury _____ dd/mm/yy	Alerts: (see reverse pg) Allergies:

Discharge date	**Requested 1st contact**	**Consultant**	**Patient ethnicity**	**Provider of choice**
dd/mm/yy	dd/mm/yy			

Diagnosis related to this referral	**Medical history**

Community health professional and service requested: Tick below **and** complete referral details box.

District nurse

- ☐ Administration of medications (attach medication authority)
- ☐ Wound care (send care plans if CNS involved)
- ☐ Acute home support (supporting info e.g. PT and OT assessments)
- ☐ IDC (size of catheter, date of insertion)
- ☐ Ostomy
- ☐ Palliative care
- ☐ Oxygen therapy (Oxygen authority)
- ☐ Continence (MSU result)
- ☐ Other _____

Public Health nurse

- ☐ Appointment DNA (child only)
- ☐ Enuresis - primary nocturnal (5yrs old and over)
- ☐ Other (child health) _____
- ☐ TB (Population Health referral only)
- ☐ Encopresis (5 yrs old and over)

Specialty nurses

- ☐ CNS Neonates/paediatrics (weight and observations)
- ☐ CNS Continence (MSU,bladder scan,PV/PR exam results)
- ☐ Nurse Practitioner Older Adult
- ☐ Collaborative Care (with hospice)
- ☐ Wound Nurse Practitioner

Referral detail (must be added to support the care required)

Other disciplines referred to ☐ PT ☐ OT ☐ SW ☐ Dietitian ☐ Other (state) _____

Rural and Community services pamphlet given to patient? ☐ Yes (Mandatory)

Discharge letter faxed with referral to CRC? ☐ Yes ☐ No

Referral source and contact details

☐ Hospital Ward/Dept _____ GP (Name/Practice if referrer) _____

Signature _____ Date _____ dd/mm/yy

Name _____ Designation _____

Contact phone number _____ *(See over page for instructions)*