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

ACC number ______________
Work related? ☐ Yes ☐ No
Date of injury ______________ dd/mm/yy

Risk factors

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)