THINK Hauora Services Referral

Name:	NHI:
Address:	Phone (H):
	Phone (C):
DOB:	Gender:
Ethnicity:	Iwi/Hapu:
GP & Practice	Referrer:
Referrer Organisation:	Referrer Phone:
Next of Kin/Guardian	NOK relationship:
NOK Phone	Patient email address:

Reason for Referral (please provide complete details): Date of referral:

Medications (please attach list):

Long Term Conditions: (Cardiovascular, Diabetes, Respiratory, Cancer, Mental Health, other):

ANY Identified Hazards/Safety/Security concerns staff should be aware of:

Clinical Information: (required information for referral to services marked with a **)

Smoker:	Height:	Weight:	BMI:	BP:	CVRA:
HbA1c:	FEV1:	FVC:		K10 Score:	Biochemistry Attached?

Is the patient/client aware of referral and agrees that relevant health professionals may be contacted? Yes/No

Who else is involved in this patient's care and have any other referrals been made?

Service being referred to (please tick):

		Te Ara Rau Access & Choice	☐
Clinical Dietitian **	☐	Here Toitū	☐
Clinical Exercise Physiologist (CEP)/ Physical Activity Educator (PAE) **	☐	Priority Cervical Smears	☐
Pasifika Health Service **	☐	Myhealthmyself	☐
Long Term Conditions - CCN-LTC **	☐	Cardiac Rehabilitation **	☐
Fracture Liaison	☐	Petals (Horowhenua)	☐
Primary care support pharmacist service	☐	HOPS (Horowhenua)	☐

Diabetes Podiatry referrals are to be completed on the Diabetes Podiatry referral form

Please email to: incomingfaxes@thinkhauora.nz or send via Healthlink EDI: tkhauora
NOTE: Primary care support pharmacist referrals to: pharmacist@thinkhauora.nz