# PRIMARY CARE POAC COORDINATION REQUEST FORM

**NOTE: THIS IS FOR NON-CLINICAL REQUESTS MON-FRI 000-1500**

Please phone Rochelle - POAC Coordinator to inform request on **021 794 935** AND email request to: poac@thinkhauora.nz.

| POAC Criteria | |
|---|---|
| Is it safe to treat this patient in the community? | ☐ **yes** ☐ **no** |
| Would you otherwise refer this person to ED? | ☐ **yes** ☐ **no** |

| Referrer Details | | | |
|---|---|---|---|
| **Referrer Name/Role** | | **Best contact number** | |
| **Practice name** | | **Date of referral** | |
| **Consent** | | | |
| **This person has consented to this referral** ☐ **yes** ☐ **no** | | | |
| **If no – please state legal status of person giving consent.** ☐ **Enacted EPOA** ☐ **Welfare Guardian** ☐ **Parent/Guardian (for child ≤ 17)** ☐ **Other - Please state** _____ **Name and Contact of this person** _____ | | | |

| Patient Details | | | |
|---|---|---|---|
| **First Name** | | **Last Name** | |
| **NHI Number** | | **DOB** | |
| **Gender** | | **Best Contact Number** | |
| **Address** | | **GP Practice** | |
| | | **Primary Language** | |
| **Ethnicity** | | **Interpreter Required** | ☐ yes ☐ no |
| **SAFETY RISKS/ALERTS** | | | |

| Clinical Details | |
|---|---|
| **Patient diagnosis** | |
| **Reason for request** | |