Te Whatu Ora
Health New Zealand
Waitematā

Pacific Health Service

[*PLACE PATIENT LABEL HERE*]			
First Name: ______________________		**Gender:** ________	
Surname: __________________________		**Ph:** ________________	
Address: ____			
Date of Birth: ____________		**NHI#:** _______________	
Ward/Clinic: ____________		**Consultant:** _______________	

Referral to Pacific Support Service

Referrer's Name:			**Date:** __/__/___
Designation:			**Service/Ward:**
Contact #:	**Mobile:**		**Hospital:**
URGENCY	☐Today	☐Within 24 hrs	☐From 2 – 5 days

PATIENT ETHNICITY AND COMMUNICATION

ETHNICITY	**Primary Contact:** ☐**Patient** ☐ **Caregiver** **Details:** ____________________________________
☐ New Zealand European ☐ Fiji ☐ Māori ☐ Kiribati ☐ Samoa ☐ Other Pacific people ☐ Cook Islands Māori ☐ Chinese ☐ Tonga ☐ Indian ☐ Niue ☐ Other Asian ☐ Tokelau ☐ Other (please specify) ☐ Tuvalu (Tick as many as needed)	**Patients First Language(s):** **Interpreter required:** Yes ☐No ☐ **Language(s):** ____________________________________

Medical Diagnosis / Active Issues	**Vulnerability Classification**	**YES**	**NO**
	Progressive neurological condition/deteriorating health condition/poor prognosis	☐	☐
	Presence of cognitive issues, mood change	☐	☐
	Complex physical health issues	☐	☐
	Primary caregiver for a family/whānau member(s)	☐	☐
	Lives alone/no family support/no fixed abode	☐	☐
	Social Welfare needs	☐	☐
	Other **Specify:** ___________________________	☐	☐

ALERTS/ALLERGIES	**MOBILITY AND DEPENDENCY**	**Is patient aware of referral?**
☐**MRSA/ESBL and other multiresistant orgs** ☐**Allergies-send ALERTS form** ☐**Other-send ALERTS form**	☐Independent ☐Walk ☐Dependent ☐Chair ☐Bed	Yes ☐ No ☐

REASON FOR REFERRAL

____

____

____

____

____

Complete this form and email it to Pacific Support Service	Pacificreferrals@waitematadhb.govt.nz
For immediate or urgent assessment please call	021 225 0016

Referral to Pacific Support Services