Te Whatu Ora
Health New Zealand

SLARK HYPERBARIC UNIT
91 Calliope Rd
Devonport

REFERRAL FORM FOR HYPERBARIC TREATMENT

Patient Name: **NHI:** **D.O.B**

Address: **phone number:**

Name of referrer:

Contact number:

Reason for referral (Include brief history of condition):

Date of recent chest x-ray (insp and exp): The patient will need to have had a CXR done in the past 6 months and the results must be faxed or emailed to the unit.

ACC 45 / claim number (if available)

Please email this form to: chris.sames@waitematadhb.govt.nz
OR, fax to (09)4457016