COUNTIES MANUKAU HEALTH

kidz first
Children's Hospital & Community Health
Tamariki Mā

Affix patient's identification label here

KIDZ FIRST COMMUNITY HEALTH REFERRAL FORM

Date ____________ & Time ____________ of Referral

Service referring to (see below): ____________

CLIENT DETAILS

LAST Name: ____________ Parent/Caregiver: ____________ Ph: ____________

First Name: ____________ Other Contact: ____________ Ph: ____________

A.K.A: ____________ GP: ____________ Ph: ____________

DOB: ________ Sex: ______ NHI: ________ School: ____________

Address: ____________ School Phone: ____________ Room No: ________

____________ Dog at home: Yes ☐ No ☐

____________ Transport: Yes ☐ No ☐

Ethnicity: Eur/Pakeha ☐ Maori ☐ Pacific Is. ☐ Asian ☐ Other ____________

Country of Birth: ____________ Language Spoken: ____________

NZ Resident: Yes ☐ No ☐ Date of Entry into NZ (if known) ____________

REASON FOR REFERRAL (P.T.O. if required) REPORT ATTACHED ☐

Duration of concerns: ____________

Do Parents/Caregiver/Student know of: Referral? Yes ☐ No ☐ Your Concerns? Yes ☐ No ☐

REFERRAL SOURCE - External M. of Ed. Spec. Ed.

School ☐ G.P. ☐ M. of Ed. Spec. Ed. ☐ C.Y.F. ☐ Other DHB ☐

Well Child Provider ☐ Self Referral ☐

Parent/Caregiver ☐ Other ☐ ____________ (please specify)

Internal

☐ EC
☐ Maternity
☐ Ward
☐ Neonatal
☐ Other ____________

Name: ____________
(please print)

Signature: ____________
(of Referrer)

Designation: ____________ Contact Details: ____________

PLEASE EMAIL REFERRAL TO ONE OF THE FOLLOWING:

SERVICE

☐ **Kidz First Centre for Youth Health**
Email: cfyh@middlemore.co.nz

☐ **Kidz First Child Development**
Email: CDTreferrals.generic@middlemore.co.nz

☐ **Kidz First Home Care Nursing**
Email: KidzFirst.HomeCareNurses@middlemore.co.nz

All referral for Primary Nocturnal Enuresis - Pukekohe
Email: pukekohe.publichealthnurses@middlemore.co.nz
Post: Public Health Nurses Office, Pukekohe Hospital,
Tuakau Road, Pukekohe

☐ Kidz First Public Health Nursing

☐ **Clendon**
Email: manphn@middlemore.co.nz

☐ **Otara**
Email: Otara.PublicHealthNurses@middlemore.co.nz

☐ **Papakura**
Email: Papakura.PublicHealthNurses@middlemore.co.nz

☐ **Pukekohe**
Email: Pukekohe.PublicHealthNurses@middlemore.co.nz

DATE ENTERED ☐

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OTHER AGENCIES INVOLVED

Oranga Tamariki ☐ M. of Ed. Spec. Ed. ☐ R.T.L.B. ☐ ACC ☐ OTHER ☐

S.W.I.S. ☐

DATE/TIME	ADDITIONAL NOTES

COUNTIES MANUKAU DHB USE ONLY

Accepted ☐ Priority of action ☐ Within 0-72 hours ☐ 1-2 weeks ☐ 1 month ☐

Rating of referral Rating 1 ☐ Rating 2 ☐ Rating 3 ☐

Declined ☐ Advised to refer on to ______________________ (please specify)

Referral source notified Verbally ☐ In writing ☐

Date ______________________

Name (please print)	Signature

Counties Manukau District Health Board

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