Waitemata District Health Board

Best Care for Everyone

Child Health Service

[*PLACE PATIENT LABEL HERE*]

First Name: _____ **Gender:** _____

Surname: _____ **Ph:** _____

Address: _____

Date of Birth: _____ **NHI#:** _____

Ward/Clinic: _____ **Consultant:** _____

Referral (Child) - Internal

Fax ALL Child Health Referrals To: 837 8877 (External) or 46877 (Internal) Ph: 0800 247 333 (Ext) or 46577 (Int)
Email: ChildHealth.Referrals@waitematadhb.govt.nz

☐ Children's Community Nurse		☐ Cultural Case Worker		☐ Public Health Nurse	
☐ Community Child Health - Allied Health (specify):					
Referral faxed:	☐ Yes ☐ No	Date:		Time:	
Referred from (*organisation or service*):					
Name of Referrer and Designation:		Contact Phone Number:			
Date First Visit Required:		Date of Discharge:			

Family details			
ACC:	☐ Yes ☐ No	ACC no:	
Primary Care Givers full names:		Relationship to child:	
Alternative Contact/Work No:		Mobile:	
Consent to referral	☐ **Yes** ☐ **No*** ***from parents/ caregiver***		
Language spoken:		Interpreter required:	☐ Yes ☐ No
Discharge Address:			
School:			

Clinicians involved					
GP:		Phone No:		Address:	
Paediatrician(s):					
Other clinicians					
Follow up Appointment:	☐ Yes ☐ No	Date:		Place:	

Diagnosis, relevant history and reason for using current service:

Reason for referral / Equipment required /desired outcome:

Relevant Social/Cultural issues and concerns:			
Oranga Tamariki involvement	☐ Yes ☐ No	Oranga Tamariki Site/ Social worker (if known):	
Parents administering medication:	☐ Yes ☐ No	Transport:	☐ Yes ☐ No
Community Needs Assessment req'd:	☐ Yes ☐ No	Dog at home:	☐ Yes ☐ No
Other Services Involved:	☐ Yes ☐ No	IPV Screening:	☐ Yes ☐ No

Discharge Recordings									
Temp:		Pulse:		Resp:		$Sp0_2$:		Weight:	
Allergies:									
Medication/Prescription chart completed and present:	☐ Yes ☐ No								

Referral accepted:	☐ Yes ☐ No	**Actions if declined:**	
Triage (office use only)	☐ P1 ☐ P2 ☐ P3		

Referral (Child) - Internal