Waitematā District Health Board
Best Care for Everyone

Older Adults & Home Health

Fax: (09) 486 8997

Tel: (09) 486 8974

Mr ☐ Mrs ☐ Ms ☐ Miss ☐	**Given names:**	**NHI:**	
Family Name:	**Preferred Name:**	**DOB:**	**Sex:**
Home Address:		**Day Phone:** **Mobile Phone:** **Night Phone:**	
NZ Resident: Yes ☐ No ☐	**Ethnicity:**	**Interpreter needed:** Yes ☐ No ☐	**Language:**

Older Adults & Home Health Referral

Discharge/ visiting address:	**Date:**	**Caregiver name:**	**Relationship:**
	Patient/caregiver consented to visit: Yes ☐ No ☐	**Caregiver address:**	**Day phone:** **Night phone:**
Phone:			

Diagnosis:	**ACC** Yes ☐ No ☐	**Community card number:** **Expiry Date:**

Reason for referral:

Relevant medical information:	**Medication:**	**Allergies:** **Alerts:**

Patient home situation:

	Able	Needs help
Eating & drinking	☐	☐
Cooking/ shopping	☐	☐
Housework/ laundry	☐	☐
Hygiene: sponging/bath/shower	☐	☐
Dressing	☐	☐
Toileting	☐	☐
Mobility	☐	☐
Sleeping pattern	☐	☐
Other:	☐	☐

Additional information:

Referrer			
	GP ☐ **Specialist** ☐ **Locum** ☐ Name, address, phone, fax & email if different from above:	**Hospital** ☐ Name: Contact person: Phone: Fax: Email:	**Other** ☐ Name: Contact person: Phone: Fax: Email:

OA&HH Referral