COUNTIES MANUKAU HEALTH

kidz first Children's Hospital & Community Health Tamariki Ki Te

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 FAX REFERRAL TO ONE OF THE FOLLOWING:

SERVICE

☐ Kidz First Centre for Youth Health	Ph: 261 2272	Fax: 261 2273
☐ Kidz First Child Development	Ph: 263 0792	Fax: 263 0539
☐ Kidz First Home Care Nursing	Ph: 263 0796	Fax: 263 0539

All referral for Primary Nocturnal Enuresis
Fax: 09 237 0670
Post: Public Health Nurses Office, Pukekohe Hospital, Tuakau Road, Pukekohe

☐ Kidz First Public Health Nursing

☐ Mangere	Ph: 259 3851	Fax: 267 7776
☐ Manurewa	Ph: 259 3851	Fax: 267 7776
☐ Otara/Papatoetoe	Ph: 270 9060	Fax: 270 9061
☐ Eastern Suburbs	Ph: 270 9060	Fax: 270 9061
☐ Papakura	Ph: 295 1280	Fax: 295 1277
☐ Pukekohe	Ph: 237 0660	Fax: 237 0670

DATE ENTERED ☐

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OTHER AGENCIES INVOLVED

C.Y.F. ☐ 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

KIDZ FIRST COMMUNITY HEALTH REFERRAL FORM