Te Hononga
O Tamaki me Hoturoa

519 Great South Road, Otahuhu
PO Box 8139, Symonds Street
Auckland
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DIABETES SELF MANAGEMENT EDUCATION
REFERRAL FORM

Attention: **DSME Service**

From: ____________________

Date Sent: ____________________

PATIENT DETAILS

NHI Number: ____________________

Gender: **Male / Female**

Ethnicity: ____________________

Date of Birth: ____________________

Full Name: ____________________

Preferred Name: ____________________

Contact Numbers: ____________________

Address: ____________________

____

Quintile: ____________________

PROVIDER DETAILS

Providers Name: ____________________

Practice Name: ____________________

Practice Address: ____________________

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REFERRAL DETAILS

Patient Consent: ____________________

Course Type: **Morning / Evening**

First Language: ____________________

Please send referrals to either of the following:
Post: PO Box 22588, Otahuhu
Auckland 1640
Fax: (09) 973 0789
Email: dsme@tehononga.org.nz