



# Whanau Ora Team– Nursing Referral Form Auckland DHB

This free mobile community service is offered to **Maori** (and Non-Maori with socio-economic disadvantage) aged 18+ years residing within the Auckland DHB area

**Eligibility Criteria (as above plus)**

- At risk or current Cardiovascular disease/diabetes
- May have long term condition
- Client has ability to improve and become self managing of health and well being from Nursing, Lifestyle and social intervention

**Exclusion**

- This service does not duplicate services already contracted for by the MOH, ACC or DHB or requiring specialist care (e.g. Patients receiving end stage/palliative care, dialysis)***
- Cognitive conditions and addictions are excluded. Stable Depression can be referred.***

**Date of Referral** \_\_\_\_\_

**Patient Details: (Attach Label or enter)**

Surname: \_\_\_\_\_

First Name: \_\_\_\_\_

NHI: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

DOB: \_\_\_\_\_ F / M \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Mob \_\_\_\_\_

**Referrer Details**

Name: \_\_\_\_\_

Professional Title: \_\_\_\_\_

Address: \_\_\_\_\_

Ph Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

HPI (Facility/Individual): \_\_\_\_\_

**GP Details if different from referrer**

Name: \_\_\_\_\_ GP Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

HPI (Facility/Individual): \_\_\_\_\_

**Consent and Safety PLEASE COMPLETE BEFORE REFERRING**

Yes/No: Patient consents to information sharing between Whanau Ora service and Health Providers involved in care

Yes/No: Home Alerts e.g. Dogs, Drugs **If yes please specify**

Yes/No: Interpreter required: Language spoken \_\_\_\_\_

**Other Services involved:**

\_\_\_\_\_

**Clinical diagnoses and any known social issues:**

\_\_\_\_\_

**Reason for Referral:**

\_\_\_\_\_

**Please attach the following information to referral if not available on Test safe :** Recent appropriate labs; screenings (height, weight etc); Long Term Medications; Allergies; any alerts we should be aware of; discharge from hospital letters.

**Thank you for the referral**  
**Please notify us if you don't receive an acknowledgment letter within 5 working days**

**Fax/Email referral form to: Email : [info@tehononga.org.nz](mailto:info@tehononga.org.nz); Fax: 09 9730789**