southseas HEALTHCARE

Life Launch / Resilient Young People [RYP]
Referral Form

Title:	FAMILY NAME	FIRST NAMES	D.O.B.	M/F
NHI:		Ethnicity:		

Residential Address			Next of Kin Details	
Street / number			In case :	
Suburb			Does this person live at the same address? Y / N	
City			Address if different from patient: Yes	
Day Phone:		Mobile:		
Postal address		Fax:	Phone/Mobile:	Relationship:
Email:			Email:	
Do you wish to receive text messages? Yes ☐ No ☐		Interpreter required Yes ☐ No ☐	**Language Spoken:**	

GP Information:

Name:	Address:
Phone:	Fax:
Email:	

Support service required [please tick box]

- ☐ active lifestyle
- ☐ alcohol and drug
- ☐ asthma or respiratory support
- ☐ cardiovascular disease support
- ☐ cervical / mammography screening support
- ☐ contraceptive, STD advice and sexual health education
- ☐ diabetes support
- ☐ hospital discharge follow up care
- ☐ immunisation support
- ☐ injury prevention support
- ☐ intellectual disability support
- ☐ maternity and/or support
- ☐ mental health (youth or adult)
- ☐ nutrition support
- ☐ obesity prevention and intervention
- ☐ palliative care
- ☐ Pasifika Ola Lelei [gambling harm minimisation]
- ☐ rheumatic fever support service
- ☐ school dental support
- ☐ smoking cessation support
- ☐ social services support
- ☐ other ______________________

Additional Information [medical history]:

Allergies:

Reason for referral

Other Agencies involved in patient care:

- ☐ CYFs
- ☐ WINZ
- ☐ Police
- ☐ School
- ☐ Immigration
- ☐ other services
- ☐ Other service ....

Please indicate whether this is a self-referral or an agency referral (tick box]

- ☐ Self Referral
- ☐ GP
- ☐ Agency Referral
- ☐ Hospital
- ☐ Nurse
- ☐ Other: ....

Referrer name: Contact number:

Email: Role:

OFFICE USE ONLY

Stamp	Date referral received:	Date actioned:	Staff member assigned to:	Discharge Date:
	01/09/2016			

Additional information continue: