Re–centre

(PRD) CONFIDENTIAL

Patient referral form

Date	NHI	ID

Patient details

Surname	Phone
First names	Mobile
Preferred first name	Email
Address	
City/postcode	Date of birth
Occupation	Place of birth
Relationship status	Gender
Ethnicity	Sp.pronoun

Principal care – contact person	Contact ICE number
Relationship	Email

Referral details

◯ **Regular GP** (please provide the following contact details)

Email:

Practice name:

Phone:

Address:

Fax:

◯ No GP

Referral request

◯ **Psychiatrist** (Specialist name if known:)

◯ **Psychologist** (Specialist name if known:)

◯ **Specific interventions:**

Priority:

◯ High (please call to discuss)

◯ Moderate

◯ Low

Funding

◯ Corporate

◯ **Insurance** – Insurer name: Insurance number:

◯ Self-funding

◯ Other

Patient information

Presentation and current state
(please record presentation and symptoms, specific risk issues, relevant history / treatment / substance use, etc.)

please continue over as needed

Medication
(please record all names, period of use, dose / frequency, past trials)

Medical history
Please record physical findings/results, diagnoses, (previous and current):

Sensitivities
(eg. food/medication reactions, special needs)

How did you hear about Re-centre?

Are you interested in attending any Re-centre CME seminars? ◯ Yes ◯ No

Would you like to hear more about the services Re-centre offers by joining our email list? ◯ Yes ◯ No

Please return the completed form to: email referrals@recentre.co.nz, fax 09 282 4872