

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

Next of Kin – 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: _____) Priority:

Psychologist (Specialist name if known: _____) High (please call to discuss)

Specific interventions: _____ 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