Pouwhenua Clinics Referral Form

Poutiri Trust
MAORI DEVELOPMENT ORGANISATION

Referrer- Name *Contact Details*

Date		**Pt Name**
DOB:	**Address**	**Age NHI**
Gender **Male ☐** **Female ☐**	**Ph Hm:** **Wk:** **Cell**	**NOK & Contact**
GP Name		**GP Address**
GP Ph:		**GP Fax:**
Reason for referral (tick) Diabetes ☐ Respiratory☐ Cardiovascular ☐		
Response Time **1 month ☐ 2 month ☐ 3 months ☐**		
Past Medical History		
Medications		**Lab Results**
Service provided Self Management education ☐ Medication management ☐ Smoking cessation support ☐ Diet and Weight Management ☐ Insulin Starts ☐ Podiatry ☐ Re-engage patient back to GP ☐ Re-engage Patient to Secondary services ☐		**Able to assist with hard to reach patients in** **EBOP** Waimana ☐ Taneatua ☐ Ruatoki ☐ Te Teko ☐ Opotiki☐ **WBOP** Matapihi ☐ Maungatapu ☐ Judea ☐ Bethlehem ☐ **Southern BOP** Reparoa ☐ Murapara ☐

Please send Referral to Attention Gina Berghan (MN, DNS)
Poutiri Trust P.O.Box 148 Te Puke

Email: rberghan@poutiri.com Ph: 5736413 or 0272680516