REFERRAL TO COMMUNITY ASTHMA/COPD NURSE EDUCATOR

PATIENT DETAILS

Referral Date: / / / / /

D.O.B:

Surname: First Name(s):

Gender : Male female

NHI No.: Ethnicity: Iwi (if identified):

Address :

Other Contact details: Home: Work:

Mobile: Fax:

Email: NZ resident: ☐ Yes ☐ No

Occupation:

GENERAL PRACTITIONER INFORMATION

HPI No.: Medical Council Number:

GP Name:

GP Practice:

Practice Address:

Phone: Fax: Email:

Hospital/ED admission ☐ Urgent ☐

Community referral ☐ Non Urgent ☐

Presenting problem for referral

Asthma ☐ COPD ☐ Bronchiolitis ☐ Spirometry Screening ☐

Pulmonary Rehab ☐ Nebuliser hire ☐

Other: .....

Smoker ☐ Non smoker ☐ Years smoked ----------

Current Long term Conditions

Current Medications

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Atrovent ☐ Beclazone ☐ Bricanyl ☐ Duolin ☐ Flixotide ☐ Pulmicort ☐ Oxis ☐
Salbutamol ☐ Seretide ☐ Serevent ☐ Spiriva ☐ Symbicort ☐ Vannair ☐ Spacer ☐

Other: .....

Patient information

Spirometry report attached ☐ Discharge summary attached ☐

Education session prior to discharge ☐ Management plan done ☐

ICU admission ☐ Recent admission ☐

Comments

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This patient agrees that their personal health record for this presentation can be passed onto Asthma & Respiratory Management BOP Inc. or Disability Resource Centre Trust and understands that a representative from there will contact them.

Patient or Parent/Caregiver Signature: .....

Referring Doctor/RN Name: (please print) .....

Referring Doctor/RN Signature: ....

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