## REFUGEE REFERRAL FOR TB SCREENING WELLINGTON REGION

Receiver Details			
To: National Public Health Service		Attn: Refugee PHN	
Email: GW-NPHSRefugee@tewhatuora.govt.nz		Phone: 04 570 9002	
Referrer Details			
Agency/ GP:		Sender:	
Email:		Phone:	
Date Sent:			
Contact Dataile of Key For	with Manufact On success		
Contact Details of Key Far	mily Member/ Sponsor	Company of	
First name/s:		Surname:	
Ethnicity:		Gender:	
Language/s spoken by whā	nau:		Interpreter required: □Yes □No
Address:		Τ	
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	sure ALL individuals who	require screening ar	e listed below.
Individual Requiring Scree	ening		
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DOB:	NHI:	Gender:	Ethnicity:
Address:			
Phone:		Email:	
Significant health or social of	concerns?		
Individual Requiring Scree	enina		
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Individual Requiring Scree	ening		
First name/s:	T.	Surname:	
DOB:	NHI:	Gender:	Ethnicity:
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Phone:		Email:	
Significant health or social of	concerns?		

Individual Requiring	Screening		
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DOB:	NHI:	Gender:	Ethnicity:
Address:			
Phone:		Email:	
Significant health or s	ocial concerns?		
Individual Requiring	Screening		
First name/s:		Surname:	
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Significant health or s	ocial concerns?	•	
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Individual Requiring	Screening	-	
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Phone:		Email:	
Significant health or s	ocial concerns?		
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Please forward this form to: Refugee PHN, National Public Health Service. **E:** <u>GW-NPHSRefugee@tewhatuora.govt.nz</u>. The information contained in the above message is legally privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that use, dissemination, distribution or reproduction of this message if prohibited. If you have received this message in error, please notify us immediately. Thank you.