

# REFERRAL TO SCHOOL PUBLIC HEALTH NURSE

Date:	Email to <a href="mailto:schoolPHN@huttvalleydhb.org.nz">schoolPHN@huttvalleydhb.org.nz</a>
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**Consent from parent/caregiver must be obtained before the public health nurse can action this referral**

Parent/caregiver consent given:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not asked
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If no, please explain:
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Referred by:	Relationship to student:
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## STUDENT DETAILS

First name:	Surname:
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DOB:	Age:	NHI:
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Sex:	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Indeterminate	GP:
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Ethnicity (select all that apply):	<input type="radio"/> NZ European	<input type="radio"/> Māori	<input type="radio"/> Samoan	<input type="radio"/> Tongan	<input type="radio"/> Niuean	<input type="radio"/> Indian	<input type="radio"/> Chinese
	<input type="radio"/> Cook Island						
	<input type="radio"/> Other (please specify):						

Iwi:	Language/s spoken:
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Student's school:	Teacher:
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Does the child have a disability?	<input type="radio"/> Yes	<input type="radio"/> No
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If yes, what is the disability:
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## PARENT/CAREGIVER DETAILS

Full name:	Relationship to student:
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Email:	Phone number:
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Address:
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Full name:	Relationship to student:
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Email:	Phone number:
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Address:
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## REASON FOR REFERRAL (please select at least one)

<input type="radio"/> Accidental injury	<input type="radio"/> Discharge from ears	<input type="radio"/> Sore throat
<input type="radio"/> Alcohol and other drugs	<input type="radio"/> Food concerns	<input type="radio"/> Sores/itchy skin or head
<input type="radio"/> Allergy	<input type="radio"/> Hearing problems (attached ENROL report)	<input type="radio"/> Speech problems
<input type="radio"/> Behavioural concern	<input type="radio"/> Medical/medication advice	<input type="radio"/> Suspected infection
<input type="radio"/> Breathing concern	<input type="radio"/> Mental health	<input type="radio"/> Truancy
<input type="radio"/> Child protection/report of concern	<input type="radio"/> Sexual health	<input type="radio"/> Vision problems (attached ENROL report)
<input type="radio"/> Dental	<input type="radio"/> Social	<input type="radio"/> Vomiting/diarrhoea
<input type="radio"/> Developmental/learning disorders	<input type="radio"/> Soiling	<input type="radio"/> Wetting
<input type="radio"/> Other (please specify):		

## ADDITIONAL REFERRAL INFORMATION


## WHAT OTHER HEALTH/SOCIAL AGENCIES OR PERSONS ARE INVOLVED WITH THE CHILD'S FAMILY?
