REFERRAL TO SCHOOL PUBLIC HEALTH NURSE

Health New Zealand
Te Whatu Ora

Date:	**Email to phadmin@wairarapa.dhb.org.nz**

Consent from parent/caregiver must be obtained before the public health nurse can action this referral

Parent/caregiver consent given:	◯ Yes	◯ No	◯ Not asked
If no, please explain:			
Referred by:	Relationship to student:		

STUDENT DETAILS

First name:	Surname:	
DOB:	Age:	NHI:
Sex: ◯ Male ◯ Female ◯ Indeterminate	GP:	
Ethnicity (select all that apply): ◯ NZ European ◯ Māori ◯ Samoan ◯ Tongan ◯ Niuean ◯ Indian ◯ Chinese ◯ Cook Island ◯ Other (please specify):		
Iwi:	Language/s spoken:	
Student's school:	Teacher:	
Does the child have a disability?	◯ Yes	◯ No
If yes, what is the disability:		

PARENT/CAREGIVER DETAILS

Full name:	Relationship to student:
Email:	Phone number:
Address:	
Full name:	Relationship to student:
Email:	Phone number:
Address:	

REASON FOR REFERRAL (please select at least one)

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

ADDITIONAL REFERRAL INFORMATION

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