AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Maternity Service

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Please ensure you attach the correct visit patient

Date faxed:	Patient Address: _____ _____ Patient Phone Number: _____

Referral to: ☐ Obstetrician ☐ Physician ☐ Virtual review ☐ Clinic review ☐ Other

Referred by:	Woman's LMC:
Name	Name
Phone	Phone
Fax	Fax

Woman aware of referral Yes / No

Primary Language Spoken: Interpreter Required Yes / No

Gravida Parity LMP:_____Sure / Unsure *(circle)* EDD dates EDD by USS

PLEASE CHECK WITH WOMAN RE: EARLIEST SCAN AND INCLUDE **ALL SCAN REPORTS** WITH REFERRAL.

Booking and registration forms sent to Private Bookings? Yes / No Date sent:

(Note appointment can only be made once complete booking and registration forms received by Private Bookings. If not previously sent, please attach to this referral and fax to Walk in Centre on 09 630 9781)

Priority ☐ 10 days ☐ 2 weeks ☐ 1 month ☐ Other

Current concerns and reason for referral:

Active Problems

1)

2)

3)

4)

5)

Reason for referral (Including relevant history and factors)

SEE ELECTRONIC HEALTHWARE REPORT FOR REFERRAL OUTCOME

SECONDARY REFERRAL FORM

CR3509

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

National Women's Maternity Service

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

SECONDARY REFERRAL FORM

CR3509