Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

REFERRAL TO SCHOOL PUBLIC HEALTH NURSE (PHN)

Date of referral: ______________________

Student's school: ______________ Room No: ________ Teacher: ______________

Name of student: (Surname) ______________ (First name/s) ______________

Also known as: ______________________

DOB: ______________ Age: ________ Gender: Male Female Other

Ethnicity: ______________________ Iwi: ______________

Home address: ______________________

Phone No: (home) ____________ (work) ____________ (mobile) ____________

Email address: ______________________

GP: ______________________ Language spoken at home: ______________

Parents/Caregivers please provide contact details

Name: ______ Relationship: ______ Address: ______ ______ Home phone: ______ Work phone: ______ Mobile phone: ______ Email: ______ ______	Name: ______ Relationship: ______ Address: ______ ______ Home phone: ______ Work phone: ______ Mobile phone: ______ Email: ______ ______	Name: ______ Relationship: ______ Address: ______ ______ Home phone: ______ Work phone: ______ Mobile phone: ______ Email: ______ ______

Reason for referral

- ☐ Absenteeism
- ☐ Accident injury
- ☐ Alcohol & other drugs
- ☐ Allergy
- ☐ Behavioural concern
- ☐ Breathing problem
- ☐ Child protection/report of concern
- ☐ Dental
- ☐ Developmental/learning concern
- ☐ Discharge from ears
- ☐ Food concerns
- ☐ Health advice
- ☐ Mental health
- ☐ Sexual health
- ☐ Social
- ☐ Soiling
- ☐ Sore throat
- ☐ Sores/itchy skin or head
- ☐ Speech problems
- ☐ Suspected infection
- ☐ Vision and Hearing concerns (attach ENROL report)
- ☐ Vomiting/diarrhoea
- ☐ Wetting
- ☐ Other

Additional information: ______________________

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Referred by: ______________ Relationship to student: ______________

Parent/Caregiver consent given: ☐ Yes

(It is very important that consent from caregiver is obtained before the PHN can action the referral)