REFERRAL TO SCHOOL PUBLIC HEALTH NURSE

Health New Zealand
Te Whatu Ora

Date:	**Email to schoolPHN@huttvalleydhb.org.nz**

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

Parent/caregiver consent given:	◯ Yes	◯ No
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?