# REFERRAL TO SCHOOL PUBLIC HEALTH NURSE

Te Whatu Ora
Health New Zealand
Capital, Coast, Hutt Valley and Wairarapa

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

**Consent from Caregiver must be obtained before the PHN can action this referral**

Student's school: _____ Teacher: _____

First name: _____ Surname: _____

DOB: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Other

Ethnicity: _____ Iwi: _____

GP: _____ NHI: _____

Language/s spoken at home: _____

**Parent/Caregivers details**

Name: _____ Relationship to student: _____

Address: _____

Phone number 1: _____ Phone number 2: _____

Email address: _____

Name: _____ Relationship to student: _____

Address: _____

Phone number 1: _____ Phone number 2: _____

Email address: _____

Does the child have a disability? ☐ Yes ☐ No

If yes, what is the disability: _____

**Reason for referral (please select at least one)**

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

**Additional referral information:** _____

What other health/social agencies or persons are involved with the child's family? _____

Referred by: _____ Relationship to student: _____

Parent/caregiver consent given: ☐ Yes ☐ No ☐ Not asked

If no, please explain: _____