nelson asthma society inc
Better respiratory health for New Zealanders

NELSON BAYS PRIMARY HEALTH

RESPIRATORY NURSE EDUCATOR SERVICE

REFERRAL FORM

FAX TO: 03 539 4958

Date referral received:

CONTACT DETAILS

SURNAME	FIRST NAMES		
DATE OF BIRTH	NHI	Male	Female
PARENTS / GUARDIAN NAME			
ADDRESS			
PHONE (Day Time)	(Evening)	(Mobile)	

ETHNICITY (Tick ✓ all groups person identifies they belong to)

NZ Māori		NZ European / Pakeha	
Pacific Island (not further defined)		European (not further defined)	
Other European		Samoan	
Cook Island Māori		Tongan	
Niuean		Asian (not further defined)	
Other (Please specify)			

BACKGROUND INFORMATION

Referral Agency	Regular GP
Date of Referral	Referrer

Smoking Status Current Smoker □ Past Smoker (more than 12 months) □ Never Smoked □ Other Smokers in house □

Reason for Referral Patient Education & Support □ Spirometry (**Please see * below**) □ Nebuliser hire □

Current Medications

Other Medical Conditions

Relevant Treatment in Hospital if post-discharge referral. Please include Dx medications

Safety issues identified if home visiting ?

***STANDING ORDER AUTHORISATION FROM GENERAL PRACTITIONER**

This is a requirement if patient is to undergo spirometry (valid for 1 year before re-authorisation required)

I authorise the above named patient to be given 400mcg SALBUTAMOL for the purpose of assessing reversibility, during Spirometry testing. (If Spirometry is indicated).	Doctors Name Practice Signature Date NZMC Number

PATIENT CONSENT INFORMATION

Has the patient verbally consented to this referral?	Yes	No
Has the patient verbally consented to receiving communication from the Respiratory Nurse Educators via text messaging?	Yes	No