

Community Nursing Referral Form

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Date of referral:	GP:	GP Telephone:
Client Name:	Title:	M/F:
Address:		
Date of Birth:	Mobile:	Telephone:
Ethnicity:	NHI Number:	Is this injury related to work? Yes No
Date of Injury:	Cause of Injury:	
ACC Claim Number:		
ACC Case Manager:		
Alternative Contact:	Relationship:	Telephone:

Reason for referral to community services

Physically unable or unsafe for client to attend PHC PHC determined that complexity of injury requires additional expertise	Client requires service outside of PHC practice hours Other:
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Nursing Intervention Required

Date of first visit required:

Wound Care	IDC	Intermittent	Enteral Feeding
Continence	SPC	Bowel	Medication Administration
Other (specify):			

Wound	Location:	Dimensions:	Infection Present? Yes No
	Skin Tear: Grade 1 2 3 N/A	Burn: Superficial: Partial: Full Thickness: N/A:	
	Swab Taken: Yes No	Other:	
	Dressing Management:		

IV Medication	IV medication to be administrated: Yes No	Medication given to patient: Yes No
	IV Leur/Piccc insitu: Yes No	Signed medication prescription given to patients: Yes No
	Details:	

Medical Diagnosis and History

Current Medications

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Home Situation

Potential Risks

Lives alone: Yes No	Natural supports: Yes No	Dogs/animals	Challenging Behaviours
Additional Comments:		Drugs	Smoker
		Alcohol	Other (specify):

Referred By:	Position:	Contact number:
Attachments: Discharge summary	Medication prescription	ACC 45
GP letter/report		

Please e-mail or scan referral form to: nursing@healthcarerehab.co.nz