## Outreach Immunisation Referral Form



Scan/Email Referrals to: enquiries@poutiniwaiora.co.nz

| Date of referral:                                                                                | NHI:    |                  | Referred by: |  |  |  |
|--------------------------------------------------------------------------------------------------|---------|------------------|--------------|--|--|--|
| Child's First Name:                                                                              |         | Child's surname: |              |  |  |  |
| Medical Conditions or relevant information e.g. allergies / reactions to previous immunisations: |         |                  |              |  |  |  |
| Date of birth:                                                                                   | Gender: | F / M            | Ethnicity:   |  |  |  |

| Address:                                 |                                                                           |                      |                 |  |  |
|------------------------------------------|---------------------------------------------------------------------------|----------------------|-----------------|--|--|
| Home Phone:                              |                                                                           | Cell Phone:          | Email Address:  |  |  |
| Mother/Primary Caregiver:                |                                                                           |                      |                 |  |  |
| 2nd Contact Name:                        |                                                                           |                      | - Phone Number: |  |  |
| Relationship:                            |                                                                           |                      |                 |  |  |
| Family GP:                               |                                                                           | Name of<br>Practice: | Date last seen: |  |  |
| Practice Nurse/Contact/Person Referring: |                                                                           | Phone:<br>Fax No:    |                 |  |  |
| Referral to OIS:                         |                                                                           |                      |                 |  |  |
| Sibling NHI Numbers:                     |                                                                           |                      |                 |  |  |
| Immunisations/Catch up overdue:          |                                                                           |                      |                 |  |  |
| Date                                     | Type of contact e.g phone, letter, email, Messenger, home visit requested |                      |                 |  |  |
|                                          |                                                                           |                      |                 |  |  |
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