Helensville Birthing Centre
TE PUNA WHANAU KI TE AWAROA

REFERRAL

Mother's name: _____

Address: _____

Ph number: _____

Email: _____

NHI: _____ EDD: _____/____/_____

Baby's name: _____

Gender: Male / Female

DOB: _____ Age: _____

NHI: _____

GP: _____

LMC:

Date sent: ____ /____ /____ **Date received**: ____ /____ /____

Referred to: _____

Referred by: Name: ..... Signature: ..... Designation: .....

(Preferred feedback via... Well Child Bk Ph call / Txt ..... fax ..... Email..... N/A)

Active Issues

1 _____

2. _____

3. _____

4. _____

5. _____

Ethnicity

- ☐ NZ European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other

Interpreter required **Yes** ☐ **No** ☐

Reason for referral

_____

_____

_____

_____

_____

_____