Partnership Community Worker (PCW) Referral

Referrer to Complete: Date of Referral: _____

REFERRER

Name: _____ Ph: _____

Address: _____ Fax: _____

_____ Email: _____

PATIENT/CLIENT

NHI: _____ D.O.B: _____

Patient/Client Name: _____ Ethnicity _____

Address: _____ Interpreter Required ◯ Yes ◯ No

Ph:_____Mobile:_____ Enrolled/Not Enrolled ◯ Yes ◯ No

Email:_____ GP/Medical Practice_____

Reason for Referral:

Detail all agencies currently involved with Patient/Client (ie GP, Health, Social Services)

_____ _____

_____ _____

_____ _____

Client Consent Obtained by Referrer: ◯ Yes ◯ No

Are there any safety concerns that we should be aware of?

Criminal Offending ◯ Yes ◯ No

Domestic Violence ◯ Yes ◯ No

Dogs on Property ◯ Yes ◯ No

Significant Mental Illness ◯ Yes ◯ No

Other (Please Specify) ◯ Yes ◯ No

_____

To forward this referral to the appropriate PCW please refer to the PCW allocation/contact details form at www.pegasus.health.nz/direct-to-patient-services

Follow-up to Referrer – PCW to complete

Patient/Client Name::_____ NHI: _____

Partnership Community Worker (PCW) allocated _____

Contact No:_____ Date of first contact: _____

Date	What needs to be done: (comments can be made by referrer and/or PCW)	Agreed by: Client/PN/PCW/Other
	1.	
	2.	
	3.	
	4.	
	5.	

Date	Actions taken:	Completed by

Feedback given to referral source by (email/phone/letter/fax/ medtec) on: _____

Feedback/ evaluation form provided to Patient/Client ◯ Yes ◯ No Date _____

Feedback/ evaluation form provided to Referrer ◯ Yes ◯ No Date_____