Pegasus™
partners in health
kia atawhai ki te tangata

PCW - Partnership Community Worker Referral

Attention (PCW Name):________________________________ Date of Referral: ________________________________

PATIENT/CLIENT Name: ________________________________ NHI: ________________________________

Caregiver (if child): ________________________________ School (if child): ________________________________

Gender:____________________D.O.B: __________________ Ethnicity: ________________________________

Address: ________________________________ Interpreter Required ◯ Yes ◯ No

________________________________ GP/Medical Practice: ________________________________

Phone:______________________Email:______________________________________ Enrolled/Not Enrolled ◯ Yes ◯ No

Current Diagnosis/Health Issues: ____

____

REFERRER Name: ________________________________ Ph: ______________________ Fax: ______________________

Address: ________________________________ Email: ________________________________

Client Consent Obtained for Referral to PCW ◯ Yes ◯ No

Purpose of Referral:

Outcome Expected by Referrer:

Any agencies currently involved with or referrals made for Patient/Client (ie GP, Health, Social Services), please provide name and contact details:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

PCWs frequently visit the client's home. Please give full details of **all safety concerns** that the PCW needs to be aware of to ensure their safety:

To forward this referral to the appropriate PCW please refer to the PCW allocation/contact details form at
www.pegasus.health.nz/health-professionals/partnership-community-workers

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____