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

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:

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:

_____ _____

_____ _____

_____ _____

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

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