TAUTOKO HAUORA
REFERRAL FORM

Pegasus™

PEGASUS HEALTH

This form can be returned to Pegasus Health at 401 Madras Street, Christchurch Central *or* by email to TautokoHauora@pegasus.health.nz

CLIENT DETAILS

Full Name :

Caregiver's Full Name:
If you are submitting this on behalf of someone under 18 years of age

School:
If relevant

NHI:
Leave blank if NHI is not known

General Practice:
Leave blank if the client is not enrolled with a general practice

Date of birth

DAY MONTH YEAR

Mobile Number:

Email:

Physical Address:

Gender:
- ☐ Wāhine | Female
- ☐ Tanē | Male
- ☐ He ira kē anō | Another gender

Ethnicity:

Pronouns:
Leave blank if not known

Is an interpreter needed? ☐ Yes ☐ No ☐ Not sure

REFERRER DETAILS

Referrer Full Name :

Agency:

Mobile Number:

Email:

Physical Address:

If you are making this referral on behalf of a client, do you have consent to make the referral?
- ☐ **Yes**
- ☐ **No**

PLEASE TURN OVER TO COMPLETE YOUR REFERRAL

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REFERRAL

What are the client's current health issues or diagnosis?

What is the purpose of this referral?

What is the expected outcome of this referral?

Which agencies is the client already involved with (for example GP, health services, social services)?

Are there any safety concerns to be aware of when visiting the client's home?

Any other comments:

Thank you for completing this form. Please return the form to Pegasus Health at 401 Madras Street, Christchurch Central *or* by email to TautokoHauora@pegasus.health.nz

THANK YOU NGĀ MIHI NUI