

Complete & Email to: massey.clinic.pn@massey.ac.nz

Ph (06) 350 5180

REFERRAL IS FOR: Name: _____ DOB: _____ NHI: _____ Gender: _____ Address: _____ Postcode: _____ _____ (attach Bradma / ID label if available)	They are: Patient <input type="checkbox"/> OR Family member <input type="checkbox"/> Contact phone numbers: _____ Email: _____
Contact person & relationship if different (if child must give caregiver): _____	

Client (client's caregiver) has consented to referral / being contacted by the Service: <input type="checkbox"/> Yes <input type="checkbox"/> No For child referral, confirm both parents consented to referral: <input type="checkbox"/> Yes If not, please contact service coordinator
Client can be seen: <input type="checkbox"/> Face to face <input type="checkbox"/> Zoom <input type="checkbox"/> Phone Preference: _____
Messages can be left if the client is unavailable: <input type="checkbox"/> On cell <input type="checkbox"/> Landline <input type="checkbox"/> Text <input type="checkbox"/> With family member
Client (client's parent/caregiver) would like a support person present at initial appointment: <input type="checkbox"/> Yes <input type="checkbox"/> No

REFERRAL IS FROM: Name: _____ Title: _____ Date: _____ Contact details (email/ph): _____ Contact details for consultant/GP for future communication (email/ph): _____

Ethnicities (tick all that apply): Māori NZ European Pacific People Asian Other: _____

Qualifying Condition: Diabetes Cardiovascular Respiratory Renal Paediatric

Diagnosis and current situation:	(If family member, please provide patient information)
What would you like Massey Health Conditions Psychology Service to assist with?	
Other services involved with care or referrals in process?	
Safety/Risks: Are there any current safety issues (risk of harm to self, to others, from others):	
Brief outline of current treatment/medication:	
Prognosis:	
Child Only: Are there any care/custody/protection/access issues?	
Inpatient only: please state ward number & anticipated admission/discharge date:	

Priority: Routine Moderate High

If you have indicated **high priority** please phone the Service on 06 350 5180 to discuss response timeframe

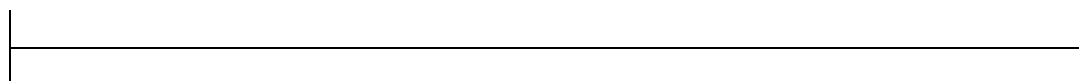
Place a mark that, to your knowledge, best describes your patient's pattern of attendance to health services:

Example:



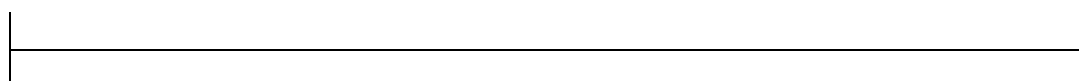
Frequency of attendance to health services

Infrequent (e.g., less than once a year) Medium (e.g., once a month-six weekly) High (e.g., once a fortnight)



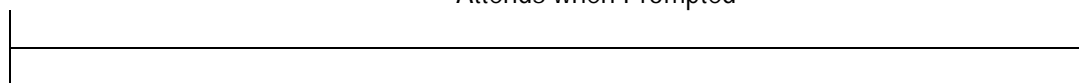
Frequency of admissions to hospital

Infrequent (e.g., less than once a year) Medium (e.g., twice yearly) High (e.g., four times yearly)



Attendance to appointments

Consistently Misses Appointments Sometimes Misses Appointments
Attends when Prompted Rarely Misses Appointments



Estimate your patient's adherence to treatments by placing a tick in the appropriate box:

Medication regimen

Unlikely Acceptable Excellent

Exercise and diet

Unlikely Acceptable Excellent

Other Lifestyle changes (e.g., smoking, alcohol)

Unlikely Acceptable Excellent

Level of Motivation

Low Medium High