**Allied Health Referral – CWH Outpatients**

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| **PATIENT DETAILS** | | | | | | | | |
| **Phone** | Home: Mobile: | | | | | | | |
| **Urgency** | **Please see next few days**  **See in 1-2 weeks**  **This can wait a few weeks** | | | | | | | |
| **Details** | Parity: Weight: Height: BMI: | | | | | | | |
| **Gynaecology** (not Physio)  Date of surgery:  ......... / …...... / ……… | | **Antenatal**  Gestation:………………wks  EDD: ……… / ……… / ……… | | | **Postnatal** (< 6 wks)  Date of delivery:  ……… / ……… / ………  Gestation at delivery: ….…. wks | | |
| **Diagnosis/ relevant medical history** |  | | | | | | | |
| **Referrer details** | Print name:  Designation: | | | | | | Date: ......... / ......... / ……… | |
| **LMC (if not referrer)** | Print name: Contact number: | | | | | | | |
| **PHYSIOTHERAPY FAX 80442 (ext.364 0442)** | | | | | | | | |
| **Initial treatment** | Physiotherapy handout / education has already been given in an attempt to alleviate symptoms prior to making this referral. | | | | | | | |
| **Reason for referral** | **Musculoskeletal**  Significant back/pelvic pain \*Pt reported pain level (0-10) =…./10  Persistent wrist / hand symptoms  Large Rectus Diastasis (postnatal)  Severe mobility issues | | | **Gynaecological**  Mild uterine or vaginal prolapse  (not protruding from the vagina)  Mild urinary or faecal incontinence | | | | |
| **Comments** |  | | | | | | | |
| **IMPORTANT NOTE** | **Please refer directly to Gynaecology Assessment Unit (GAU) for medical review if women has:** | | | | | | | |
| * Sudden/significant  postpartum incontinence | | * Severe uterine prolapse  (protruding from vagina) | | | | | * Significant perineal pain |
| **DIETITIAN FAX 85860 (ext. 364 4860)** | | | | | | | | |
| **Reason for referral** | **Pregnancy**   Singleton or  Multiple | | | | **Postnatal**  Food allergy & breastfeeding | | | |
| Hyperemesis (see HealthPathway)  BMI > 35 + < 25/40  BMI <18.5  Hb <100g/L and/or Ferritin<20  Triplet pregnancy  Poor oral intake and/or no weight gain | Food allergy / aversion / intolerance  Vegan  Previous Bariatric surgery  Less than 18 years old | | |
| **Specialist Only**  BMI > 32 incontinence and/or prolapse  Pelvic pain / Endometriosis (with IBS, food aversion / intolerance, constipation)  Polycystic Ovary Syndrome and BMI > 30  BMI > 32 and Infertility | | | |
| **Gynaecology – Oncology**  BMI >30 incontinence and/or prolapse  Pre-op - Assessed as at risk of malnutrition  Post-op – ongoing dietetic review required | | | |
| **Additional comments** |  | | | | | | | |

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| **PATIENT DETAILS** | | | | | | | |
| **Phone** | Home: Mobile: | | | | | | |
| **Urgency** | **Please see next few days**  **See in 1-2 weeks**  **This can wait a few weeks** | | | | | | |
| **Details** | Parity: Weight: Height: BMI: | | | | | | |
| **Gynaecology**  GAU  Colp  EPAS  OPD  Date of surgery:  ......... / …...... / ……… | | **Obstetric**  Gestation:………………wks  EDD: ……… / ……… / ……… | | | **NICU**  Date of delivery:  ……… / ……… / ………  Gestation at delivery: ….…. wks | |
| **Diagnosis/ relevant medical history** |  | | | | | | |
| **Referrer details** | Print name:  Designation: | | | | | | Date: ......... / ......... / ……… |
| **LMC (if not referrer)** | Print name: Contact number: | | | | | | |
| **SOCIAL WORK & COUNSELLING FAX 81139 (ext. 364 1139)** | | | | | | | |
| **Reason for referral** | Care and protection  Family violence  Mental Health risk  Security risk  Parenting concerns | Significant medical problems impacting health of women, unborn, newborn, children, family  Counselling related to grief, loss or adjustment | | | Pre-decision TOP counseling  Discharge supports, community agency involvement required i.e. convalescence and placement  Housing, resources | | |
| **Additional information** | Please provide further detailed information regarding your concerns … | | | | | | |
| **Partner / Family / Contact people** | Print name: …………………………………………  Phone: ………………………………………………. | | | Print name: …………………………………………  Phone: ………………………………………………. | | | |
| **Agreement** | The patient is aware of this referral:  Yes  No | | | | | | |
| **Agencies involved** | CDHB  Oranga Tamariki  Mental Health  Child Health & Safety  Other (specify): | | | | | | |
| **MĀORI HEALTH WORKER FAX 85001 (ext. 364 4001)** | | | | | | | |
| **Reason for referral** |  | | | | | | |