**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:………………wksEDD: ……… / ……… / ……… | **[ ]  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
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| **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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| **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:………………wksEDD: ……… / ……… / ……… | **[ ]  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** |  |