GREEN PRESCRIPTION (GRx) REFERRAL FORM - **HEALTH PROFESSIONALS**– NORTH SHORE AND RODNEY

1. Please note all fields are compulsory
2. **EMAIL** the referral to [grx@harboursport.co.nz](mailto:grx@harboursport.co.nz) or FAX to 09 415 4594
3. Notify your patient that a Patient Support Person will be in touch within 10 working days of receiving the referral
4. Contact Harbour Sport if you have any questions on 09 415 4610

**Section 1 – Patient Details (All Fields Compulsory\*)**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Medical Conditions (All Fields Compulsory\*)**

**Patient Medical Conditions**

Respiratory conditions Depression/Anxiety CVD High Cholesterol High blood Pressure Heart Conditions

High Blood Pressure Weight Loss Support Arthritis Injury Mental Health Conditions Epilepsy

Stroke Joint replacement Osteoporosis Stress**Smoker** \_\_\_\_ smokes per day

**Diabetes**

Pre-diabetic (HbA1c 41-49mmol) Gestational diabetes  T2 T1

I have referred this person to DSME (Diabetes Self-Management Education)

**Other relevant information (e.g. pregnant)**

Click here to enter text.

**Physical Activity**

Green Prescription Programme: (Please tick one) **Stanmore** **Bay**  **Glenfield**

I recommend that for your health and wellbeing, you should:

* (e.g.) Go for a brisk walk, or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intensity: very light \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Light \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Moderate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For at least \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Times per week

**Section 3 – Referrer information (All Fields Compulsory\*)**

Referrer Health Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Agency Referred from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed (Doctor/Nurse) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By noting my name above I confirm that I have explained the GRx process and the patient has consented for their details to be forwarded to HARBOUR SPORT GRx who will provide them with support and advice.