

ACTIVE FAMILIES/TEENS REFERRAL FORM ALL HEALTH PROFESSIONALS WEST AUCKLAND, NORTH SHORE AND RODNEY

1. Please note all fields are compulsory
2. **EMAIL** the referral to grx@harboursport.co.nz or FAX to 09 415 4594
3. Notify your patient that a Family Support Worker will be in touch within 10working days of receiving the referral
4. Contact Harbour Sport if you have any questions on 09 415 4657

Section 1 – Patient Details (All Fields Compulsory*)

First Name:

Surname:

Gender: Male Female

Date of Birth:

Ethnicity

Weight (If known):

Street Address:

Height (If known):

Suburb:

Postcode:

Home Phone:

or Mobile:

or Work:

Section 2 – Medical Conditions (All Fields Compulsory*)

BMI:

Patient Medical Conditions (Please list all medical conditions, including weight issues/stress)

Diabetes

Pre-diabetic (HbA1c 41-49mmol)

T2

T1

Other relevant information

Section 3 – Referrer information (All Fields Compulsory*)

Referrer Health Professional:

Phone:

Extn:

Clinic/Agency Referred from:

Postal Address:

Date:

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