



Clinical Nurse Specialist Mental health referral form

Patient name: _____

Current location: _____

DOB: _____ NHI _____

Address: _____

Phone: _____

Diagnosis:

GP Name: _____

Reason for referral

Expected date of discharge: _____

Patient must be in agreement to assessment; if they do not consent then I can support the referrer by case consultation.

Referral source

Print Name: _____

Signature: _____

Date: _____

Fax to 06 8690538

Ward 11

Joanne Love

Cell no. 021 812 453