

WellSouth Primary Health Network Dietitian
Referral Form



Patient details				
Name:		NHI:	Ethnicity:	
Does the patient need a translator: Y/N		What language does the patient need translation for:		
Address:				
Phone: Mobile:		DOB:	Sex: M/F	Smoker: Y/N
Reason(s) for Referral				
Diagnoses (Please tick all relevant)				
<input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> Type 2 diabetes	<input type="checkbox"/> Overweight/obese	<input type="checkbox"/> Elevated blood lipids	Other (please list)
Measurements				
	Weight (kg)	Height:	BMI (kg/m ²):	Blood Pressure:
Biochemistry				
	HbA1c	Cholesterol	Lipids	eGFR
Medications: (please attach a list)				
Referred by: (please put name and details below)				
Name:				
Practice:			Phone:	
Please fax or mail referrals to: Southland Region Attention: Dietitian 40 Clyde Street PO Box 649 Invercargill Phone: 03 214 6436 Fax: 03 2140325			Otago Region Attention: Dietitian 333 Princes Street PO Box 218 Dunedin 9054 Phone: 03 4771163 Fax: 03 4771168	