Wellbeing Clinic Referral Form

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Women's Health Service

The referral will not be processed unless all the information required on this form is completed. Incomplete forms will be returned to the referrer for completion and re-referral. Referral will be declined if the woman has previously been under Mental Health Services. She will need to be referred directly to Maternal Mental Health not Women's Clinics.

Date referred:		
Woman's name:		NHI:
Address:		
Contact phone no: Home:	Mobile:	Work:
Contact person:		
e-mail address:		
DOB / Age:	G/P:	LMP:
Gestation at time of referral:	EDD:	By dates: ☐ By early scan: ☐
Reason for referral:		
Previous Mental Health History: ☐ No - Complete referral ☐ Yes - Refer directly to Maternal Mental Health		
LMC/Referrer name:		
Contact details:		
Regular GP:		
Contact details:		

When completed email to: RES-PrimCareRef@ccdhb.org.nz