active+ Mt Eden

REFERRAL FORM

Auckland Lymphoedema and Rehabilitation

Patient details:

Name:		NHI number:
Email:		Phone:
Date of Birth: ______ /______ /______	☐ Male ☐ Female	Ethnicity:
Diagnosis:		
Surgical plan:		
Previous or planned chemotherapy/radiotherapy:		
Referral to be initiated:	☐ Immediately	☐ After date ______ /______ /______
Reason for physio referral: ☐ Cancer rehabilitation ☐ Early intervention lymphoedema surveillance/prevention ☐ Lymphoedema management		

Referred by:

Name:	Practice name:
Phone:	Email:
Signature:	Date: