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**HAWKES BAY DHB Clinical Outreach Team COVID-19 – Referral Information**

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| --- | --- |
| **Date** |  |
| **Referrer****Practice/Role****Contact Number****Email** |  |
| **Patient Information****Name** **NHI****DOB****Address****Contact Phone Number** |  |
| **COVID-19 Status** | 1. **Covid Positive**

**or** 1. **Isolating close contact, asymptomatic**

**or** 1. **Isolating close contact, symptomatic**

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| **Diagnoses** |  |
| **Presenting Concerns****What is needed** |  |
| **Social Situation** |  |
| **Known Risks** |  |
| **Other Comments** |  |

**Please send this referral form to the Health Hawkes Bay GPCCU at**

**covid@healthhb.co.nz** **and they will send to the HBDHB Clinical Outreach Team**

**You will receive an email acknowledgement from the HBDHB Outreach Team**