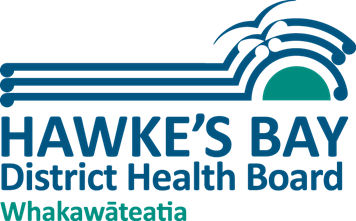
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**HAWKES BAY DHB Clinical Outreach Team COVID-19 – Referral Information**

|  |  |
| --- | --- |
| **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** |
| **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**](mailto: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**