



**MATE TAIHĀ REFERRAL**  
**Gout Support & Treatment**

Please complete all sections and email this referral to: [gotgout@hbdhb.govt.nz](mailto:gotgout@hbdhb.govt.nz)  
Alternatively, you can call our Mate Taihā team on 0800 687 010

\*These sections **must** be completed

\*Consent for referral to service obtained:  Yes  No

\*Name: ..... Date of birth:

.....

NHI (if known): .....

\*Contact number: .....

Current Address:

.....  
.....  
.....

Alternative contact: ..... Relationship to Client.....

Phone: .....

Has client had a confirmed diagnosis of Gout:  Yes  No

Is the client currently taking medication for Gout:  Yes  No

Is the client enrolled with a GP:  Yes  No

If yes, please provide GP details:

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Reason for referral:

.....  
.....  
.....  
.....  
.....

Referred by..... Location.....

Signature: ..... Date: .....

Phone (ext. no.): .....

