Referral Form
Clinical Services

Client Details

NHI		Date of Referral	___/___/_____
Title		Date of Birth	___/___/_____
Full Name		Known as	
Address			
Contact No		Gender	☐ Male ☐ Female ☐ Other
Email		Ethnicity	
GP		Neurologist/Specialist	

Whanau\Next of kin

Name		Contact No	
Relationship		Other information	

Referrers Details

Name		Designation	
Contact No		Email	
Does the patient agree to the referral?	Yes ☐ No ☐	Is the GP aware of the referral?	Yes ☐ No ☐
Diagnosis			

Medical History

Reason for referral

Hazards (e.g. Dog on property, smoker etc)

SEND TO: referral@parkinsons.org.nz
or mail: Parkinson's NZ, PO Box 11 067, Manners Street, Wellington 6142