

Cardiovascular Disease & Diabetes REFERRAL FORM

PASIFIKA INTEGRATED HEALTH CARE LTD
 TEL 410-0251; FAX 410-9695



North Shore



PASIFIKA INTEGRATED FAMILY MEDICAL CENTRE LTD
 TEL 410-0275; FAX 410-0282

PERSONAL DETAILS

(Please ensure that all information are recorded correctly)

Referred to: Referred from:

Name:

Address:

Phone No.:

Alternative Address:

Phone No.:

D.O.B: Gender: (Circle one) Male / Female

Cultural Identity:

Occupation :

Religion:

Next of Kin: Phone/Mob

Health History:

GP: Phone No.:

Address:

Reasons for Referral:

Action Needed: URGENT Within 24 hours ASAP

Observations:

Blood Pressure	Weight
Blood Sugar Level	Height
Cholesterol	Waist Circumference
Lifestyle	Medication

Referred by: _____ Date: _____
