Referral to Orthotist

Email completed form to: info@orthnz.com
Phone: 06-920 3350

ORTHOTICS**NZ**
Tautoko Hauora

Personal Details / or Patient Label

◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Other	Gender: ◯ Male ◯ Female ◯ Other
First Names:	NHI:
Surname:	D.O.B:
Address:	Phone:
	Mobile:
	Work:
Email:	Occupation:

Referral Details

◯ **Urgent** ◯ **Semi-Urgent** - 2-3 weeks ◯ **Next Availability** ◯ **Pre OP** - Upcoming Surgery ◯ **Post OP -** 4-6 weeks post surgery

Provisional Diagnosis:

Prescription Goal:

Suggested Orthotic Treatment:

ACC or Funder Information

Funder: ◯ ACC ◯ ICPMSK ◯ Accredited Employer ◯ Private ◯ Other	
Other funder:	
ACC No.	DOI:
Case Manager:	DOS:
Case Manager Email:	Location of Surgery: ◯ TDHB ◯ SX ◯ Other
Nature of Injury:	

Referrer's Details

Name:	
Practice Phone:	Email:
Signature:	Date: