

HOME VISIT REQUEST FORM

Please complete and email to nth.homevisits@awanuilabs.co.nz with referral form.

Name of Patient: _____

NHI / DOB: _____

Address: _____

Patients should be bedridden or have impaired mobility, mentally unwell or physically disabled AND have no support person to provide transport to a collection centre.

Please note: Residents that are living independently at Rest Homes/Villages that are mobile are not eligible for this service

For further information please phone 09 438 4243 or 0800 667 522

Reason for Request

☐ Housebound

☐ Special Medical Request Reason: _____

Period for which home visits are requested

☐ One visit only Date: _____

☐ Regular

* Frequency of visit _____ Start date: _____

***Please note: Regular requests for INR tests are performed "PRN" – as needed. Please notify us when testing is required and allow 24 hours notice, where possible.**

Staff Safety

To ensure the safety of our staff we ask that the questions below are filled in.

***Please note: We will phone the patient and ask about any animals on the property. Animals must be restrained and/or isolated from the working environment prior to and for the duration of the visit.**

1) Has this patient ever displayed aggressive behaviour or any behaviours of concern?

No ☐ Yes ☐ If yes, please specify _____

***Please note: A caregiver/family member or medical practice staff may be required to accompany us**

2) Does this patient have a contagious illness that we need to be aware of?

No ☐ Yes ☐ If yes, please specify _____

3) I certify that this patient is eligible for the free home visit service No ☐ Yes ☐

Referrer Name: _____ Date: _____