

ACUTE SERVICE (24HR) 0508 497 372 – Medical Professionals Only

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Mobile: _____

NHI: _____ Date: _____

Please tick indication for referral:

<p>Bubble Injury</p> <ul style="list-style-type: none"><input type="checkbox"/> Decompression Illness<input type="checkbox"/> Arterial Gas Embolism <p>Acute Ischaemic Conditions</p> <ul style="list-style-type: none"><input type="checkbox"/> Compromised Flaps/Grafts<input type="checkbox"/> Crush Injury/Compartment Syndrome<input type="checkbox"/> Reperfusion Injuries<input type="checkbox"/> Sudden Sensorineural Hearing Loss<input type="checkbox"/> Avascular Necrosis <p>Problem Wounds</p> <ul style="list-style-type: none"><input type="checkbox"/> Chronic Ischaemic Problem Wounds<input type="checkbox"/> Diabetic: <i>Ulcers/ Gangrene/ Post Surgical</i><input type="checkbox"/> Non Diabetic Problem Wounds: <i>Pyoderma Gangrenosum/Refractory Venous Ulcers/Post Surgical Problem Wounds</i> <p>Radiation Tissue Injury</p> <ul style="list-style-type: none"><input type="checkbox"/> Osteoradionecrosis<input type="checkbox"/> Soft Tissue Radiation Injury	<p>Infective Conditions</p> <ul style="list-style-type: none"><input type="checkbox"/> Clostridial Myonecrosis<input type="checkbox"/> Necrotizing Fasciitis<input type="checkbox"/> Myonecrosis Necrotizing Cellulitis<input type="checkbox"/> Malignant Otitis Externa<input type="checkbox"/> Refractory Mycoses<input type="checkbox"/> Refractory Osteomyelitis<input type="checkbox"/> Intracranial Abscess <p>Toxic Gas Poisoning</p> <ul style="list-style-type: none"><input type="checkbox"/> Carbon Monoxide Poisoning<input type="checkbox"/> Carbon Monoxide Poisoning - Delayed Sequelae <p>Ocular Ischaemic Pathology</p> <ul style="list-style-type: none"><input type="checkbox"/> Cystoid Macular Oedema<input type="checkbox"/> Retinal Artery/Vein Occlusion <p>Miscellaneous</p> <ul style="list-style-type: none"><input type="checkbox"/> Thermal Burns<input type="checkbox"/> Frost Bite<input type="checkbox"/> Bells Palsy<input type="checkbox"/> Adjuvant to Radiotherapy in Treatment of Solid Tumours
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Clinical Details:

Referring Doctor: _____ NZMC: _____

Department/Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____ EDI: _____