

REFERRAL FORM

Please bring this form with you along with any other documents including x-rays.

Name

Date of birth

NHI Number

Address

.....

Phone

Email

ACC number

Date of injury / when symptoms started

Diagnosis / reason for referral

.....

Hand Therapy Required:

Splint

Assessment & Treatment

Other

Referred by (signed)

..... (print)

Date

Contact details

Contact *tāmakihands* to make an Appointment

Phone (24 hours):


09 950 4849
0800 950 485

Online booking:

www.tamakihands.co.nz

Fax: 09 950 6818

Email: office@tamakihands.co.nz

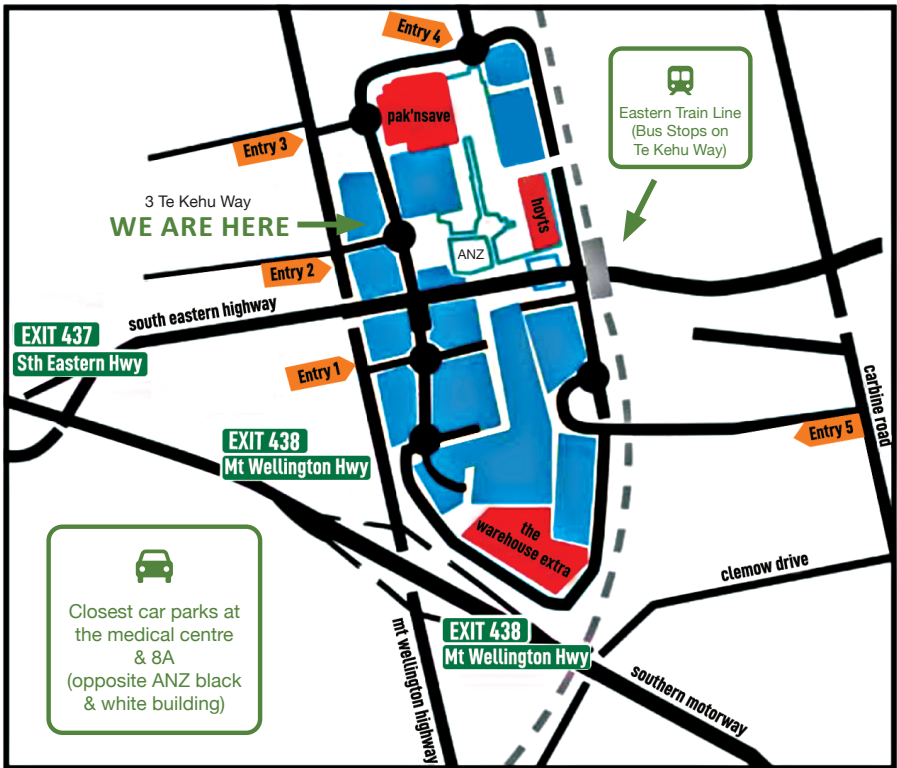
 facebook.com/TamakiHands

Location: Sylvia Park

Medical Centre, Level 1
3 Te Kehu Way
Mt Wellington
Auckland 1060

Postal Address:

PO Box 87026
Meadowbank
Auckland 1742



Your First Appointment

Day..... Date..... Time.....

Please arrive 10 minutes early to allow time to complete your paperwork.