

HOME HEALTH CARE CONTINENCE SERVICE

Northland Health
P O Box 742
WHANGAREI
Ph: (09) 430 4101 ext 7974
Fax: (09) 430 8065

The following client is transferring into your district:

NAME: _____	NMPI: _____
ADDRESS: _____	
PHONE: _____	DOB: _____
INSERT HOSPITAL LABEL (IF AVAILABLE)	

NEW CONTACT DETAILS

PATIENT NEW ADDRESS: _____ _____ PHONE: _____	ALTERNATIVE CONTACT: _____ _____ PHONE: _____
GP:	GP PHONE:
MEDICAL DIAGNOSIS: 	
CONTINENCE PROBLEMS:	MEDICATIONS:
CONTINENCE AIDS: 	
<i>Date of last issue:</i> _____	
REFERRED BY:	DATE:
NOTES: (PLEASE INCLUDE RECENT ASSESSMENT AND/OR NURSING NOTES)	



DISTRICT NURSING SERVICE
NOTIFICATION OF DISCHARGE

___/___/___

Attach Patient Label

Today the above patient has been discharged from the Whangarei District Nursing Service. During our care of this patient the following treatments/interventions were carried out:-

Summary of Treatment/Intervention

Results

Client discharged as failed to attend appointments/was not at home on two consecutive visits.

Please note we would be pleased to recommence visits at any time.

Signature Name Designation

cc. Patient

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