*Fill in only if patient label is unavailable*

Name:........................................................ DOB: .........................

NHI:…………………………………… Phone………………

Address .......................................................................................

# Hand Therapy Referral

**Presenting Condition**

**Date of Injury/Onset:** **ACC Number:**

**Injury or Diagnosis:**

**Surgery (if applicable)**

**Date of Surgery:**

**Type of Surgery:**

**Precautions:**

**Treatment Requests e.g. protocols, splint, exercises, wound care**

**Other Relevant Information e.g. past medical history, return to work**

**PLEASE EMAIL REFERRALS TO:** handtherapy@hbdhb.govt.nz

***Our alternative contact details are:***

**Phone:** 06 878 8109 extension 2717

**Mail:** Hand Therapy
Hand Therapy and Orthopaedic Dept.
Hawkes Bay Hospital
Private Bag 9014
Hastings
4156

Referrer Name……………………………………. Referrer Designation…………………….............

Signature………………………….... Phone Number…………………………… Date………………...

HAND THERAPY REFERRAL