HAVELOCK NORTH WATER CONTAMINATION
COMMUNITY HEALTH ASSISTANCE
GENERAL PRACTITIONER REFERRAL FORM

INTRODUCTION
This General Practitioner Referral form has been designed to support information within the Havelock North Water Contamination Community Health Assistance Application Form.

CRITERIA
The assistance is for people who have suffered symptoms consistent with campylobacter (caused by the Havelock North water event of August 2016) and who have continued to suffer a recognised long-term illness linked to these symptoms. Long-term is defined as six months or longer.

The assistance is intended to provide a one-off contribution towards an applicant's financial expenditure incurred as a result of the long-term illness.

INFORMATION REQUIRED:

GENERAL INFORMATION	
NAME OF DOCTOR	
NAME OF MEDICAL CENTRE/PRACTICE	
NAME OF CLIENT	
GENDER OF CLIENT	
AGE OF CLIENT	
ADDRESS OF CLIENT	
HOW LONG HAVE YOU BEEN HIS/HER GP?	

INFORMATION REQUIRED:

RISK OF CONSUMING CONTAMINATED WATER DURING THE HAVELOCK NORTH WATER EVENT IN AUGUST 2016	
Is it likely that your client consumed contaminated Havelock North water between 5 August 2016 and 12 August 2016?	◯ YES ◯ NO

HAWKE'S BAY REGIONAL COUNCIL

HASTINGS DISTRICT COUNCIL

INFORMATION REQUIRED:

SYMPTOMS CONSISTENT WITH CAMPYLOBACTER

Did your client suffer symptoms consistent with campylobacter infection during the period 5 August 2016 and 6 September 2016? (This includes the incubation period)	◯ YES ◯ NO
Were there any tests undertaken?	◯ YES ◯ NO
If yes, what were the results?	

INFORMATION REQUIRED:

LONG-TERM MEDICAL ILLNESS

Has your client experienced a recognised medical illness linked to the symptoms consistent with campylobacter infection that has lasted six months or longer?	◯ YES ◯ NO
If yes, what is the medical illness?	◯ Guillain Barre Syndrome ◯ Reactive arthritis ◯ Inflamed bowel ◯ Kidney failure ◯ Other – (please elaborate below)
What were the symptoms and severity of those symptoms in the first six months?	

INFORMATION REQUIRED:

LONG-TERM MEDICAL ILLNESS

Are you aware of any pre-existing condition/s that your client has, that may have contributed to this medical illness?	◯ YES ◯ NO
If yes, please elaborate	
Have you made a referral to any hospital specialist regarding this case?	◯ YES ◯ NO
If yes:	**NAME OF SPECIALIST AND HOSPITAL** ..... **DATE OF REFERRAL** .....

MEDICAL RECORDS / TRANSCRIPTS

Please provide any relevant medical records relating to this application.

SIGN OFF

SIGNATURE: .....

NAME OF DOCTOR: .....

DATE: .....

(MEDICAL CENTRE STAMP)

Note: the application form includes a consent form giving permission for the general practitioner to release medical information to the independent medical assessor.