Please email this referral to the AIR Team at:

RSU@tdhb.org.nz

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AIR - OUTREACH IMMUNISATION SERVICE REFERRAL FORM | | | | | | | | |
|  | | | | | | | | |
| Please note that the child you are referring **must** have been advised that their immunisation(s) is overdue. The medical centre must actively attempt to contact the child three times. Please provide details below | | | | | | | | |
|  | | | | | | | | |
| Type of Contact*e.g.: phone/text/email/letter* | | | | Date of Attempt | | | | |
| 1: | | | |  | | | | |
| 2: | | | |  | | | | |
| 3: | | | |  | | | | |
| If three attempts at contact have not been made, please provide details why: | | | | | | | | |
| Name | | | | DOB | | | NHI | Male/Female |
| Address | | | | Parent/Caregiver name and relationship to the child | | | | |
| Daytime contact number | | | | Alternative Contact Details | | | | |
| Immunisations referred for: | | | | | | | | |
|  | | **Overdue** | **Notes** | | | | | |
| 6 weeks | |  |  | | | | | |
| 3 months | |  |  | | | | | |
| 5 months | |  |  | | | | | |
| 12 months | |  |  | | | | | |
| 15 months | |  |  | | | | | |
| 4 years | |  |  | | | | | |
| **Any other relevant information to assist the Outreach team e.g. allergies, background information** | | | | | | | | |
| *Please check for any siblings and refer separately if required* | | | | | | | | |
| Referrer’s Name and Centre | | | | | Child’s GP | | | |
| Date Referred | | | | | Medical Centre Phone or Email | | | |
|  | | | | | | | | |
| OIS report back | | | | | | | | |
|  | Declined current overdue immunisations | | |  | | Declined current overdue & **all** further immunisations | | |
|  | Decline letter sent to GP | | |  | | Declined OIS service | | |
|  | Unable to contact (non-responder) | | |  | | Completed and discharged | | |