GPI Pitcairn Health Centre Operational Policy
ANNEX C: PI MO Referral Form

Date: _____

Patient Name (Print)

_____

DOB: _____ **Sex:** Male ☐ Female ☐

Status: (*Tick appropriate box(s)*):

Working Pensioner ☐ Non-working Pensioner ☐

Patient Support Person requiring their own treatment ☐

Patient Support Person not requiring their own treatment ☐

Minor ☐

Off-Island Treatment Requirement(s): *Tick appropriate box*

Medical ☐ Dental ☐ Optical ☐ Routine Check-up ☐ Follow-up ☐

Designated Destination:

New Zealand ☐ Tahiti ☐

Referral Category(s): *Tick appropriate box*

Category A ☐ Category B ☐

Does the Patient require a Category C Patient Support Person to accompany them?

Yes ☐ No ☐

If yes, what is the name of the Patient Support Person: _____

Relationship to the Patient: _____

What Referral Category is the Patient Support Person?

Category C1 ☐ Category C2 ☐

If C2, what off-island treatment requirement(s) are required?

Medical ☐ Dental ☐ Optical ☐ Routine Check-up ☐ Follow-up ☐ Other ☐

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Pitcairn Island Medical Officer:

Name: _____

Signature: _____ Date: _____

Patient's signature: _____Date: _____

Patient Support Person Signature: _____ Date:_____

Patient and/or Patient Support Person has been provided with a copy of this document

Yes ☐ No ☐