Select a region:

☐ Auckland ☐ Wellington ☐ Rotorua

REQUEST FOR ASTHMA NEW ZEALAND SERVICE

Patients Name: **NHI Number:**	**Parents Name:**
Date of Birth:	**Ethnicity you identify with**:
Address:	
Phone No:	**Alternative No**:
REFERRERS NAME: **DATE OF REFERRAL:** **ADDRESS:** **Phone No**:	
School:	
GP and Surgery: Name and Address:	
Diagnosis:	
Reason for referral:	
Other Relevant Information:	
Clients/Parents Approval for referral obtained: Yes / No (circle)	

Please, submit this referral form:

Auckland: Email: anz@asthma.org.nz Fax: 09 623 0774

Wellington: Email: wellington@asthma.org.nz Fax: 04 477 2306

Rotorua: Email: rotorua@asthma.org.nz Fax: 07 347 1017