

Rheumatic Fever (Non-Acute) Register and Referral

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

Please refer all acute cases to hospital

WORKING DIAGNOSIS

☐ NON-ACUTE case:
with Rheumatic Heart Disease (RHD)

☐ NON-ACUTE case:
Prior ARF without Rheumatic Heart Disease (RHD)

PATIENT DETAILS

Family Name	NHI	Occupation
Given Names	DOB / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address Permanent: _____ <input type="checkbox"/> Address at registration		
Ethnic Group: Tick as many boxes as you need to show which ethnic groups you belong to <input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Chinese <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) <input type="checkbox"/> Samoan <input type="checkbox"/> Niuean <input type="checkbox"/> Indian <input type="checkbox"/> Cook Island Maori Please State _____		
Country of Birth		
Date of Arrival in New Zealand / /	NZ Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	

REGISTRATION DETAILS

Date of Registration: / /	Referred to register by:	Senior Consultant at time of registration:
DHB of Domicile at diagnosis	Referrer Role: <input type="checkbox"/> Resident Medical Officer (RMO) <input type="checkbox"/> Senior Medical Officer (SMO) <input type="checkbox"/> Nurse <input type="checkbox"/> General Practitioner (G.P)	Consultant type: <input type="checkbox"/> Rheumatic Fever Physician <input type="checkbox"/> Cardiologist <input type="checkbox"/> Paediatrician <input type="checkbox"/> Infectious Diseases Consultant

RHF AND RHD DETAILS

Previous Acute Rh Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	First/Recurrence date: / /
Previous Rh Fever Admissions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of Admission: / /
Previous Cardiac Surgery for RHD? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date: / /
Has patient previously been on secondary prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Date of most recent Benzathine Penicillin or other: / /	
Estimated year of discontinuation: / /	

SUPPORTING REFERRAL INFORMATION

Please scan and attach the referral letter if sending this notification via email.
i.e. Please provide ALL the relevant paperwork that supports their diagnosis of RF in the past

PLEASE NOTE

- Filling the above form will not constitute a referral to your DHB's nursing services
- Please complete referral to nursing services, in addition to this form, as per your local DHB's policy
- Please send completed form to: Robyn Buchanan, Paediatric ID Secretary, 5th Floor, SSH
Phone: (09) 307 4949 ext. 22559 or email it to RobynB@adhb.govt.nz

**Rheumatic Fever (Non-Acute)
Register and Referral****MUST ATTACH PATIENT LABEL HERE**

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label*Please refer all **acute** cases to hospital***MEDICATION ORDER****R_x Benzathine Penicillin Injections**900 mg (1.2 megaU) IM **OR** 450 mg (0.6 megaU) IM
(if less than 30 kgs)**and lignocaine 2%**0.25 ml IM
(delete and initial if not required)**every**

21 / 28 days (circle and initial)

Estimated year of cessation _____

Signed: _____ Date: _____

Referring DR _____
(USE BLOCK LETTERS)

Medical Council #: _____

Address: _____

Date of most recent Benzathine dose _____

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Rheumatic Fever Consent for Penicillin Treatment

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

CONSENT FOR PENICILLIN TREATMENT

I wish to have an interpreter ☐ Yes ☐ No
 'Oku ou fiemaue 'aia ha'aka fakatonulea ☐ IO ☐ IKAI
 Oute maneo e I aise se fa'atonu ☐ IOE ☐ LEAI
 E hiahia ana koe ki e Tangata Whaka - Maori ☐ Yes ☐ No

If yes: Language _____

CONSENT

The information on this form will be used to arrange Penicillin injections as prescribed by your doctor and to provide statistics on this disease. The information will be given only to health workers who are involved in your care, all of whom are bound to keep it confidential. The information will also be used to improve our treatment and prevention of Rheumatic Fever. No names or personal details will be used.

I, _____ hereby consent to treatment for
rheumatic fever/rheumatic heart disease to prevent recurrent strep infections.

- Long acting Penicillin (Bicillin) by injection to be given by the Community Nurse. ☐ Yes ☐ No
- Lignocaine added to the Bicillin to numb the area around the injection. ☐ Yes ☐ No
- I understand the nature of the disease and the reasons for treatment. ☐ Yes ☐ No

	Name	Signature	Date
Patient / Parent / Guardian			
Interpreter (if required)			
Staff Member <i>Name:</i> <i>Designation:</i>			

PLEASE NOTE

- Scan completed medication order form and consent separately and upload into register
- Please complete notification to nursing services, in addition to this form, as per your local DHB's policy
- Please send completed form to: Robyn Buchanan, Paediatric ID Secretary, 5th Floor, SSH
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