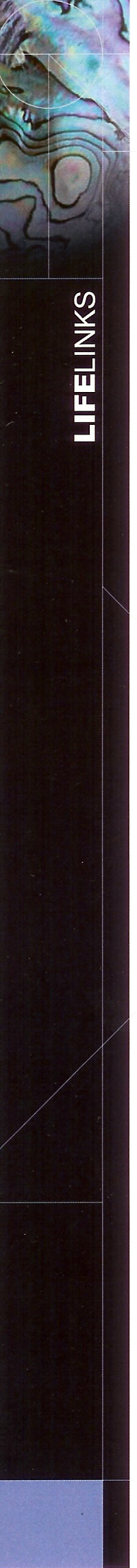
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | | | | | | | | | |
| Referral Date: | | |  | | | | | | Date of Birth: | | | |  | | | |
| Surname: | | |  | | | | | | Phone No: | | | |  | | | |
| First Name(s): | | |  | | | | | | Email: | | | |  | | | |
| Address: | | |  | | | | | | NHI No: | | | |  | | | |
| CSC No: | | | |  | | | |
| Expiry Date: | | | |  | | | |
| Ethnicity: | | |  | | | | | | NZ Residency: | | | | Yes  No | | | |
| Iwi: | | |  | | | | | | Gender: | | | | M  F | | | |
| GP: | | |  | | | | | | First Language: | | | |  | | | |
| Communication Method (Interpreter Required): | | | | | | | | | | | | | | | | |
| If the person has been identified as Maori would they like a culturally appropriate facilitator?  Yes No | | | | | | | | | | | | | | | | |
| Present Living Situation:  Living With: Alone With Spouse/Partner With other family members Others | | | | | | | | | | | | | | | | |
| Risk Factors: Yes No  If yes, please identify:  *Please attach documentation detailing risk and safety concerns and supports that are being utilised to manage these risks.* | | | | | | | | | | | | | | | | |
| **IMPORTANT:** Has the person you are referring given consent to disclose their information, and are they requesting this service? Yes No  If consent has not been obtained, give reason: | | | | | | | | | | | | | | | | |
| **ALTERNATIVE CONTACT PERSON/NOK DETAILS** | | | | | | | | | | | | | | | | |
| Surname: | |  | | | | Title: | |  | | First Name(s): | | | | | |  |
| Address: | |  | | | | | | | | | | | | | |  |
| Relationship: | |  | | | | | | | | Phone Number: | | | | | |  |
| **DISABILITY DETAILS**  *Please attach confirmation of diagnosis from a specialist and any other supporting reports* | | | | | | | | | | | | | | | | |
| **Primary:** *Include date of event or diagnosis* | | | | | | | | | | | | | | | | |
| **Secondary:** *Please use this section to outline any medical, mental health or ACC/Accident related conditions* | | | | | | | | | | | | | | | | |
| **Reason for Referral:** *Please outline the reasons for this referral, indicating the loss of function and its expected duration, and how this related to the stated disability.* | | | | | | | | | | | | | | | | |
| **Urgency of Referral:**  Non Urgent Semi Urgent Urgent | | | | | | | | | | | | | | | | |
| **Additional Info:** *Please provide any additional information you feel is relevant to this referral.* | | | | | | | | | | | | | | | | |
| **HEALTH INVOLVEMENT DETAILS** | | | | | | | | | | | | | | | | |
| Specialist Clinician: | | | |  | | | | | | | | ACC: | | |  | |
| Social Worker: | | | |  | | | | | | | | Psychologist: | | |  | |
| Therapists: | | | |  | | | | | | | | Paediatrician: | | |  | |
| Agency/Organisation: | | | |  | | | | | | | | Other: | | |  | |
| **HOSPITAL DISCHARGE DETAILS** | | | | | | | | | | | | | | | | |
| Proposed Discharge Date: | | | | |  | | | | | | | | | | | |
| Short term services in place?  Yes No Start Date: End Date: | | | | | | | | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | Agency | | | |  | | | | | |
| Address: |  | | | | | | | | | | | | | | | |
| Phone: |  | | | | | | Email: | | | |  | | | | | |
| Fax: |  | | | | | | Relationship to Client: | | | | | | |  | | |

**Office / audit use only**

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| --- | --- | --- | --- | --- | --- | --- |
| Referral received by: | Email Fax Post | | | Date received: |  | |
| Contact made within 2 working days? | | | Yes No | Referral acknowledgement letter & brochure sent: | | Yes No |
| Date entered into database: | |  | | Team Manager: |  | |