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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 [ ] NoIf 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:  |  |