



Capital Support
"Links for Living"

Level 3 Guardian House, Cobham Court
PO Box 50137, Porirua City, Wellington
Phone (04) 237-2570 Fax (04) 237-2571

Referral Form

Office Use Only:

Date Received:

Entered:

Date/Time first Assessment:

Routine Urgent –please indicate immediate safety issue and reason for urgency: _____

Does the client currently receive services through Capital Support? YES NO UNSURE

If YES please provide information on page 3 as to why this referral is being made.

CLIENT DETAILS (OR STICKIE)

NHI: _____ Date of Birth: ___/___/___ Male Female

Full Name (legal name) Mr/Ms/Mrs/Miss/Dr: _____

Preferred Name: _____

Phone: () _____

Fax: _____

e-mail Address: _____

Address (St., Suburb Town): _____

Comm. Services Card Number.: _____ Expiry Date: ___/___/___

Who would you prefer as your assessor? Male Female Ethnicity _____

Ethnicity: European/Pakeha Maori Pacific Island Asian Other: _____

NZ Resident: Yes No Unknown

Communication Method/Language Issues: _____ Interpreter required Yes No

General Practitioner: Dr: _____ Phone: _____

Address (St., Suburb, Town): _____ Fax: _____

MEDICAL DIAGNOSES & DISABILITIES

List Medical Diagnosis:

- _____
- _____
- _____
- _____
- _____
- _____
- _____

For new referrals only
Please note referrals can not be processed with out a medical specialist's report that confirms the diagnosis.

For re-referrals
Please use page 3 to identify why the new referral is being made.

List Disabilities greater than 6 months duration:

(Note: Short term, less than 6 months, disabilities refer to Care Coordination Centre for Personal Care/Home Help)

- _____
- _____
- _____
- _____
- _____
- _____

Please note eligibility is not met by a person's diagnosis alone. It is essential that the person's long term disability is also identified – this is only required for new referrals

List ACC/Accident related conditions

- _____
- _____

ACC claim registered YES NO

ACC Services: _____

