COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

Needs Assessment Service Coordination - Referral Form

This referral cannot be actioned if there is insufficient supporting information and will be returned to referrer for further information which may delay services for the client.
Please fax completed referral to (09) 276 0041 Int. 8041 or phone (09) 276 0040 Int. 8040

Client Information

Date of referral

Surname:

First Name(s)

NHI: **Ethnicity:**

DOB: **M/F**

Interpreter: Yes /No **NZ Resident** Yes/No

Client consent for referral Yes/No

Community Services Card Yes /No **ACC** Yes /No

Client Address:

Phone No.

An Alternate No.

Email [if known]:

Caregiver or Next of Kin

Name:

Phone/email:

Relationship:

Clients GP

Name:

Phone:

Referrer Details

Name:

Designation:

Contact Phone/email:

Living Arrangements / Supports -

Lives alone Yes/No

Manukau City Council Pensioner Flat -

Housing NZ Unit-
Alerts/risks-dogs, family violence, substance abuse

Main reason for Referral -

Urgency- please circle (1= very urgent)

1 2 3 4 5

Comment:

Client informed of their diagnosis Yes/No

Disability/Relevant Medical History

(include how disability affects person, functional limitations &/or type and date of any surgery/injury)

Date of relevant hospital admission-

Date of discharge from hospital-

Other known services already in place or referrals

Referral / Assessor Preference [please tick]

NASC -

Short Term Personal Health-

Other-