CMDHB Needs Assessment Service Coordination - Referral Form

This referral will be returned to referrer if there is insufficient supporting information
Please fax completed referral to (09) 276 0041 Int. 58041 or phone (09) 276 0040 Int. 58040

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

Number =

ACC Yes/No

Client Address:

Phone -

Alternate contact phone-

Email (if known)

Caregiver or Next of Kin

Name

Phone

Relationship

GP Identification

Name

Phone

Referrer Details

Name

Designation

Phone/Locater
Fax no

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 - **presenting situation**

Urgency- please circle (1=very urgent)

1 2 3 4 5

Comment:

Client informed of their diagnosis Yes/No

Disability/ Relevant Medical History- <u>please include weight in Kgs</u>
(include how disability affects person, functional limitations &/or type & date of surgery/injury)

<u>Weight –</u>
<u>Height -</u>

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-

CLTS-

Other-