



WHAKATANE: 3158 P O BOX 241
 PHONE: 07 307-8986 FAX: 07 306-0987
ROTORUA: 3040 P O BOX 1858
 PHONE: 07 349-4213 FAX: 07 349-3555
TAURANGA: 3140 P O BOX 2121
 PHONE: 07 571-0093 FAX: 07 571-0277
 AFTER HOURS EMERGENCY FREE PHONE 0800 262 477

Referral for Needs Assessment for People with Long-Term Disabilities (six months or longer)

Title:	*Surname:	*First Name(s):	NHI No:
*Residential Address:			Preferred Name:
*Phone: ()		Alternative Phone ()	Fax ()
*Date of Birth:		Community Card No:	Expiry Date:
Communication Requirements (if any):			Ethnicity:
*Usual General Practitioner:			GP's Phone: ()
Client's Preferred Contact Person – Name:			Phone: ()
Address:			Relationship:
Indicate if correspondence is to be sent to: Client, Contact Person, or Other - provide name and address of other:			

*Nature of Disability /*Reason for Referral (please describe all difficulties and attach all relevant information and clinical assessments to this form, use extra sheet if necessary):

Medical Diagnosis (if any):	
Has the client been discharged from hospital in the last six weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this referral a result of an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client receiving Hospice services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client receiving any other DHB-funded service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client/contact person agree to the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Referrer Name:	Relationship:
Address:	Organisation:
Phone: ()	Alternative Phone ()
Date:	Signature:

*** Referrals that do not contain relevant information will be returned to referrer**