

**REFERRAL FORM
 NEEDS ASSESSMENT SERVICE COORDINATION (NASC)**

Completion of this form does not constitute eligibility for Disability Support Services

PERSONS DETAILS:

Surname	Title	Mr / Mrs / Miss / Ms
First Names	NHI Number	
Also known as	Date of Birth	/ /
Address	Gender	M / F
	GP	
Phone	GP Ph	
Mobile	CSC Y / N	Expiry / /
Fax	CSC Number 00000	
Email	ACC Client Y / N	
Living Situation: <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse/Partner <input type="checkbox"/> With Family <input type="checkbox"/> Other	ACC Number	
Ethnicity: <input type="checkbox"/> NZ European <input type="checkbox"/> Maori – Iwi	<input type="checkbox"/> Other	
NZ Citizenship Y / N	NZ Residency Y / N	Interpreter Required Y / N

CONSENT FOR REFERRAL AND DISCLOSURE OF INFORMATION PROVIDED BY:

Person Yes No Parent of child (<17yrs) Yes No

If no, consent by Additional Guardian Welfare Guardian Enacted EPOA Other _____
 (Please provide documentation to confirm role)

Name of person & contact details:

ALTERNATIVE CONTACT DETAILS:

Surname	Title	Mr / Mrs / Miss / Ms
First Names	Phone	
Address	Mobile	
	Fax	
Relationship to person	Email	

PRIMARY DIAGNOSIS: (list all relevant information and attach specialist / medical reports to confirm diagnosis)

REASON FOR REFERRAL: (including events leading to referral, needs identified, safety or sensitive issues)

URGENCY? State reasons:

Which of the following categories best describe the person's disability?

<input type="checkbox"/> Intellectual	<input type="checkbox"/> Physical	<input type="checkbox"/> Sensory	<input type="checkbox"/> Chronic Health	<input type="checkbox"/> Other
<input type="checkbox"/> Autism	<input type="checkbox"/> ACC Related	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Palliative	

Functional Impairment: (likely to last longer than 6 months)

<input type="checkbox"/> Physical	<input type="checkbox"/> Range of movement	<input type="checkbox"/> Mobility	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Continence
<input type="checkbox"/> Cognition	<input type="checkbox"/> Memory	<input type="checkbox"/> Orientation	<input type="checkbox"/> Planning	<input type="checkbox"/> Initiation
<input type="checkbox"/> Communication	<input type="checkbox"/> Speech	<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision	
<input type="checkbox"/> Safety	<input type="checkbox"/> 24 hr supervision	<input type="checkbox"/> Falls risk	<input type="checkbox"/> Medication	

Impacts on:

<input type="checkbox"/> Personal Care	<input type="checkbox"/> Home Management	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Carer Stress
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OTHER SERVICES INVOLVED: – Please tick and date when referrals sent:

<input type="checkbox"/> Child Development Unit / /	<input type="checkbox"/> Occupational Therapist / /	<input type="checkbox"/> Physiotherapist / /
<input type="checkbox"/> Rehabilitation Unit / /	<input type="checkbox"/> Social Worker / /	<input type="checkbox"/> Psychologist / /
<input type="checkbox"/> Special Education / /	<input type="checkbox"/> Hospice / Palliative Care / /	<input type="checkbox"/> Mental Health / /
<input type="checkbox"/> Child Youth & Family / /	<input type="checkbox"/> Strengthening Families / /	<input type="checkbox"/> HCN / /
<input type="checkbox"/> Speech Language Therapist / /	<input type="checkbox"/> ACC - ClaimNo / /	
Is this person currently in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No – Ward:	Likely Discharge Date / /	
Referrals sent to support discharge? <input type="checkbox"/> Short Term Home Help / /	<input type="checkbox"/> District Nurses / /	

OTHER INFORMATION:

Does the person being referred require a support person present at their assessment and/or assistance with communication? If so please outline reason and state name of person and their contact details:
Does the person being referred have any cultural/religious requirements that we should be aware of? - If so please describe
Does the person being referred already receive funded support? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider Name:
Does any other person living in the home receive funded support? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of person?
Possible Hazards when visiting: eg. Access/Parking difficulties/Aggressive animals/Other. Please describe

REFERRER DETAILS:

Full name	Date of referral / /
Designation	Phone
Organisation	Mobile
Address	Fax
	Email

FOR ENABLE NASC STAFF ONLY:

Eligible: <input type="checkbox"/> DSS <input type="checkbox"/> NA <input type="checkbox"/> SC	Urgency: <input type="checkbox"/> 24hrs <input type="checkbox"/> 5 days <input type="checkbox"/> 10 days <input type="checkbox"/> 20 days	Date / /
Decline: <input type="checkbox"/> LTS-CHC <input type="checkbox"/> ACC <input type="checkbox"/> MH <input type="checkbox"/> PH <input type="checkbox"/> CMI <input type="checkbox"/> Age Related	Signature:	
Rationale & Recommendation:		