



Supportlinks REFERRAL

Please complete referral in full to assist to determine eligibility for Needs Assessment Service Coordination (NASC) Services.

Persons Details - Please complete a separate form for each person being referred:

Name: Mr/Mrs/Ms/Miss		NHI:
Address:		DOB:
		Phone:
Gender: Male/Female	Ethnicity: NZ European /Maori / Other (please state)	
Social Situation:	<input type="checkbox"/> Living alone <input type="checkbox"/> Living with others	GP:
Community Services Card No: 00000		Expiry Date:

Referrer Details:

Name:		Date:
Address:		Phone:
		Fax:
Relationship:		Email:

Consent for referral and disclosure of information provided by:

<input type="checkbox"/> Person	<input type="checkbox"/> Parent (child under 17)	<input type="checkbox"/> Guardian	<input type="checkbox"/> Additional Guardian	<input type="checkbox"/> Welfare Guardian
<input type="checkbox"/> EPOA Enacted <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Other (Please describe)		
If consent is not provided by person or the parent of a child, documentation will be required to confirm who is legally able to consent on behalf of the person.				

Contact Details - Alternative Contact:

Name: Mr/Mrs/Ms/Miss		Hm Phone:
Address:		Wk Phone:
		Cell:
Relationship:		Email:

Is the person Eligible for Publicly Funded Health and Disability Services? Yes No

Disability Eligibility:

<input type="checkbox"/> Intellectual	<input type="checkbox"/> Physical	<input type="checkbox"/> Sensory	<input type="checkbox"/> Age Related
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Other: – Including past history:

<input type="checkbox"/> Personal Health	<input type="checkbox"/> Mental Health	<input type="checkbox"/> ACC Related	<input type="checkbox"/> Palliative
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Diagnosis: Please provide relevant information e.g. specialist reports

Reason for referral:



Name: Mr/Mrs/Ms/Miss	NHI:
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Complete this page only if the person is in hospital

Reason for Hospital Admission:	Date of Admission:
	Ward:
	Likely Discharge Date:
<p><u>In-Patient Discharge Plan</u></p> <p>Is there any further treatment planned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have all rehabilitation options been explored? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have equipment solutions been explored? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there natural support options available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Referral sent to Short term Home Help? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Referral sent to Meals on Wheels? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Referral sent to District Nurses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Referral sent to Palliative Care/Hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Person lives in another DHB area? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can be assessed post discharge at home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unsafe to discharge prior to service coordination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Likely to require residential care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Previous hospital admissions in last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate dates:</p> <p>Other.....</p>	<p>Comments:</p>

FOR SUPPORTLINKS STAFF ONLY

Phone Referral Taken by:

Date:

Intake Team/Customer Services Coordinator to complete:

Eligible for DSS Services: Yes No Over 65/DHB Under 65/MOH

Deemed to be: MH PH ACC Other

IFP CMI

Decline details:

Recommendation:
