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| **CLIENT REFERRAL DETAILS** |
| **Date of Referral:** |       | **NHI (if known):** |       | **GP:**  |       |
| **Clients name:** |       |
| **Date of Birth:** |       | **NZ Citizen/Resident/CSC:** |       |
| **Address:** |       |
| **Phone Number:**  |       | **Alternative contact number:**  |       |
| **Gender:** | Male | [ ]  | Female | [ ]  | Other  | [ ]  |
| **Interpreter needed?** | Yes | [ ]  | No | [ ]  | **Yes, what language:** |       |
| **Ethnicity:** |
| **Iwi / Hapu (if known):**  |
| **Reason for referral:** |
| **Referral type:** | Internal Referral | [ ]  | External Referral | [ ]  | Self-Referral | [ ]  |

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| **Next of Kin/Emergency Contact(please provide the following information if known):**  |
| **Next of kin:**  |  | **Relationship:** |  |
| **Phone number:** |  | **Alternative contact details:**  |  |

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| **Please provide the following information (attach any supporting documentation):**  |
| **Overview of client:** |
| **Risk assessment:** |
| **Medication/Health:** Please include any known allergies including to food and/or medication |
| **Any additional information that will support referral** |

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| **REFERRER DETAILS** |
| **Referrer name:** |       | **Organisation:** |       |
| **Relationship:** |       | **Email address:**  |       |
| **Work Phone:** |       | **Alternative Number:** |       |