|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |  | |

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

|  |
| --- |
| **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** |

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