**Client Details**

|  |  |  |  |
| --- | --- | --- | --- |
| NHI |  | Date of Referral | \_\_\_/\_\_\_/\_\_\_\_\_\_\_ |
| Title |  | Date of Birth | \_\_\_/\_\_\_/\_\_\_\_\_\_\_ |
| Full Name |  | Known as |  |
| Address |  |
| Contact No |  | Gender | 🗆 Male 🗆 Female 🗆 Other |
| GP |  | Contact Number |  |
| Are they a NZ Resident? |  Yes 🗆 No 󠄀🗆 | Ethnicity |  |
| Living arrangements *e.g. alone, with whanau* |
| Language | English 🗆 Other: | Is an interpreter required? |  Yes 🗆 No 󠄀🗆 |
| Is the referral the result of an accident? | Yes 🗆 No 󠄀🗆 Date of accident: \_\_\_/\_\_\_/\_\_\_\_\_ ACC claim no  |

**Whanau\Next of kin\Carer\Informal support person\EPOA**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Contact No |  |
| Relationship |  | Has the patient agreed for us to contact them?  |  Yes 🗆 No 󠄀🗆 |

**Referrers Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Designation |  |
| Contact No |  | Email |  |
| Service |  |
| Does the patient agree to the referral? |  Yes 🗆 No 󠄀🗆 | Is the GP aware of the referral? | Yes 🗆 No 󠄀🗆 |
| Diagnosis |  |

**Reason for referral** *e.g. current issues, goals for intervention, areas of concern*

|  |
| --- |
|  |

**Profession referring to:**

|  |  |  |
| --- | --- | --- |
| 🗆 Dietitian | 🗆 Geriatrician | 🗆 Liaison Nurse |
| 🗆 Nurse Practitioner | 🗆 Occupational Therapist | 🗆 Physiotherapist |
| 🗆 Speech Language Therapist | 🗆 Social Worker | 🗆 Rehabilitation Physician |

**Additional information** *e.g. receiving supports at home.* *Attach additional sheets if required.*

|  |
| --- |
|  |

**Mobility**

🗆 Independent

🗆 Stick

🗆 Crutches

🗆 Frame

🗆 Wheelchair

**Cognition**

🗆 Alert and rational

🗆 Mildly confused

🗆 Very confused

**Skin Integrity**

🗆 Intact

🗆 Broken

**Incontinent**

🗆 Urine

🗆 Bowels

**Sight**

🗆 Good

🗆 Impaired

**Hearing**

🗆 Good

🗆 Impaired

**Communication**

🗆 Good

🗆 Impaired

**Nutrition**

🗆 Good

🗆 Poor