

LifeLinks

Nga Oranga Mekameka
A Division of Compensation Advisory Services Ltd

Intellectual, Physical and Sensory Disabilities Referral Form 0 – 65 years Tuku Tono Mō

LIFELINKS

CLIENT DETAILS

Referral Date:	Date of Birth:
Surname:	Phone No:
First Name(s):	NHI No:
Address:	CSC No:
	Expiry Date:
Ethnicity:	NZ Residency: <input type="checkbox"/> Yes <input type="checkbox"/> No
Iwi:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
GP:	First Language:

Communication Method (Interpreter Required):

If the person has been identified as Maori would they like a culturally appropriate facilitator?
 Yes No

Present Living Situation:

Living With: Alone With Spouse/Partner With other family members Others

Risk Factors: Yes No

If yes, please identify:

Please attach documentation detailing risk and safety concerns and supports that are being utilised to manage these risks.

IMPORTANT: Has the person you are referring given consent to disclose their information, and are they requesting this service? Yes No

If consent has not been obtained, give reason:

ALTERNATIVE CONTACT PERSON/NOK DETAILS

Surname:	Title:	First Name(s):
Address:		
Relationship:	Phone Number:	

DISABILITY DETAILS

Please attach confirmation of diagnosis from a specialist and any other supporting reports

Primary: (incl date of event or diagnosis)

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Secondary: Please use this section to outline any medical, mental health or ACC/Accident related conditions.

Reason for Referral: Please outline the reasons for this referral, indicating the loss of function and its expected duration, and how this related to the stated disability.

Urgency of Referral:

Non Urgent (within 1 week) Semi Urgent (within 48 hours) Urgent (within 24 hours)

Additional Info: Please provide any additional information you feel is relevant to this referral.

HEALTH INVOLVEMENT DETAILS

Specialist Clinician:	ACC:
Social Worker:	Psychologist:
Therapists:	Paediatrician:
Agency/Organisation:	Other:

HOSPITAL DISCHARGE DETAILS

Proposed Discharge Date:

Short term services in place?

Yes No Start Date: End Date:

Frequency of need for assistance with personal care: *including care provided by carers*

Less than Daily Daily More Frequently

Is night care needed? No Sometimes Most/Every Night

REFERRER DETAILS

Name:	Agency:
Address:	
Phone:	Email:
Fax:	Relationship to Client:

Office / audit use only

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Referral received by: <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Post	Date received:
Contact made within 2 working days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral acknowledgement letter & brochure sent: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date entered into database:	Team Manager: