

# LifeLinks

Nga Oranga Mekameka  
A Division of Compensation Advisory Services Ltd

## REFERRAL FORM

0 – 65 years

Tuku Tono Mō

**N.B. ALL FIELDS TO BE COMPLETED TO ENABLE THIS REFERRAL TO BE PROCESSED**

Date:	_____	DOB	_____
Client's Name:	_____	NHI No:	_____
Address:	_____	CSC No:	_____
	_____	Doctor (GP)	_____
Post Code:	_____	Doctor/ Specialist	_____
Phone	_____	Ethnicity:	_____
NOK/Guardian:	_____	Risk Factors:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	_____		
Disability/ Diagnosis:	_____		
	_____		

Communication method (Interpreter required): \_\_\_\_\_

N.B. How would client like to receive information of service

Standard  Large Print  Plain Language  Email \_\_\_\_\_

**N.B.** Has the above named person and/or caregiver been fully informed of this referral and given consent for this to occur:  Yes  No  
and aware a support person can be present  Yes  No

Indicate "significant impact" of disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If urgent, state why: \_\_\_\_\_

\_\_\_\_\_

Is care/representative required to attend?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Referrer's Name:	_____	Organisation: _____
Address:	_____	Phone: _____
	_____	Email: _____

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