National Referral Centre

Nga Oranga Mekameka
A Division of Compensation Advisory Services Ltd

NRC

Disability Support Services Referral Form
0 – 65 years
Tuku Tono Mō

CLIENT DETAILS			
Referral Date:		Date of Birth:	
Surname:		Phone No:	
First Name(s):		Email:	
Address:		NHI No:	
		CSC No:	
		Expiry Date:	
Ethnicity:		NZ Residency:	☐ Yes ☐ No
Iwi:		Gender:	☐ M ☐ 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: *Include date of event or diagnosis*

94 Disraeli Street, PO Box 2379, CHRISTCHURCH
Ph: (03) 365 9593, 0800 866 877, Email: referrals@nrcentre.co.nz

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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 ☐Semi Urgent ☐Urgent

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:

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

Office / audit use only

Referral received by: ☐Email ☐Fax ☐Post	Date received:
Contact made within 2 working days? ☐Yes ☐No	Referral acknowledgement letter & brochure sent: ☐Yes ☐No
Date entered into database:	Team Manager:

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