



Support Works

Te Roopu Tautoko Referral Form

Affix patient label here if available → Mr/Master/Mrs/Ms/Miss/Dr: Surname: <input type="text"/> First Names: NHI: DOB: Male <input type="checkbox"/> Female <input type="checkbox"/> Residential Address: Phone: Fax: Email:		NZ Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/> NZ Resident? Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnicity: European/ NZer <input type="checkbox"/> Maori <input type="checkbox"/> Iwi: Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Interpreter Required? Yes <input type="checkbox"/> No <input type="checkbox"/> Detail:
Has the person consented to this referral and the sharing of information? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Alerts: tick box for yes. Infectious <input type="checkbox"/> Dog at house <input type="checkbox"/> Difficult Access <input type="checkbox"/> Allergies <input type="checkbox"/> Other <input type="checkbox"/> Details:		
Community services card number: 00000/ Community services card expiry date: <u>Community Services Card is required for household management services. Palliative care clients are exempt from this requirement.</u>	G.P: G.P Surgery: Care Plus? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is there is an able bodied person in the home? Yes <input type="checkbox"/> No <input type="checkbox"/> Lives Alone <input type="checkbox"/> With Others <input type="checkbox"/> Detail:		
Next of Kin/ Caregiver/ Contact Person: Address: Phone (s): Relationship:		
Medical Condition/Disability:		
What is the problem? Describe areas of need, for example personal care needs and present abilities.		
If the client is in Hospital what is their intended date of discharge?		
Referrers Name (please print): Name of person completing this form if you are not the referrer: Designation & Organisation/Ward/Dept./Relationship to person: Phone: Email:		
		Referral Date:

Affix another patient label here or rewrite clients full name →

To indicate clients category of disability please tick one of the following boxes:

Life Long: for people assessed by a specialist as having a physical, intellectual or sensory disability which is likely to continue for a minimum of six months.

Health of Older People: For those people over 65 years with an age related disability or assessed as close in age and interest.

Post Acute Support/Short term service: This support will be for a period of 2-4 weeks following an acute medical event that has resulted in a person being unable to achieve activities of daily living.

Palliative Care Services: Referred by the Palliative Care service.

For people who have had an accident and require support contact ACC on 0800 101 996

**For Post Acute Support/Short term and Palliative services only:
Tick the box to show the clients choice of Home Support Provider Agency.**

<input type="checkbox"/> Presbyterian Support Home Care www.ps.org.nz	 Presbyterian Support	(03) 547 9350- Nelson Fax (03) 547 6035 Nelson (03) 577 9005 -Blenheim Fax (03) 577 9006 -Blenheim
<input type="checkbox"/> Healthcare of NZ Ltd www.healthcare.co.nz		0800 263 562 (03) 548 2009- Nelson Fax (03) 548 4948 (03) 577 9911- Blenheim Fax (03) 577 9913
<input type="checkbox"/> Access Homehealth Ltd www.access.org.nz		0800 161 444 (03) 547 5552-Nelson Fax (03) 547 9050 0800 161 444 Fax (03) 547 9050 027 673 0050 – Blenheim
<input type="checkbox"/> Nelson Home Support and Nursing Service www.healthcarenelson.co.nz (NELSON REGION ONLY)		(03) 547 2814 - Nelson Fax (03) 547 5814 -Nelson
<input type="checkbox"/> Florence Nightingale Agency www.florence2care.co.nz		(03) 548 0623 - Nelson Fax 03 548 0625 (03) 577 9343 -Blenheim Fax (03) 577 9350 -Blenheim

Support Works use only: Please tick the appropriate boxes: Accepted Declined Set up? Yes No

Palliative Service *or Post acute* *Code:*

Start Date:

End Date: