Lakes NASC – Over 65 Referral Form

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CLIENT DETAILS (referrer to complete)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms NHI Number:
Name of Client: Date of Birth:
Home Address:
Home Phone: Cell Phone:
☐ Client lives alone ☐ Client lives with other (if so specify) ________________________
Community Services Card Number: Expiry Date:
Does client have Enduring Powers of Attorney (EPOA): ☐ Yes ☐ No
If Yes, state full name of Attorney : _____ Contact No.: ______

REFERRAL DETAILS

Name of Referrer: Position:
Contact Phone Number: Fax Number:
Date of Referral: Signature:

GENERAL MEDICAL DETAILS

Name of GP: _______ GP Phone Number:
Name of any other specialist involved: _______
Formal diagnosis of dementia? ☐ Yes ☐ No

ETHNICITY & CITIZENSHIP

Tick all boxes that apply: ☐ NZ European ☐ NZ Maori ☐ Pacific Islander ☐ Other _______
First language: __ _____________________ Is an interpreter needed? ☐ Yes ☐ No
Citizenship : ☐ NZ Citizen ☐ Residency If *residency* ticked, was evidence sighted? ☐ Yes ☐ No

NEXT OF KIN DETAILS

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
Full Name: Relationship to Client:
Home Address:
Home Phone: Work Phone: Cell Phone:

IMPORTANT!

Has the person you are referring given consent to disclose their information? ☐ Yes ☐ No
1. Are they requesting this service? Yes ☐ No ☐
2. If no, give reason: _____

Urgency of Referral

☐ Urgent – 24 hours ☐ Semi-urgent – 48 hours ☐ Non Urgent – 1 week

List Safety Concerns:

Age-related disability of greater than 6 months duration:

Other Health / Disability Concerns:

Other Health Professionals / Community Support Services Involved?

☐ Field Officer ☐ Social Worker ☐ Occupational Therapist
☐ ACC ☐ Meals on Wheels ☐ Other

Other Services Currently Received?

Client is currently receiving short term services: ☐ Yes, Provider: _____ ☐ No
Date services commenced: Date services to finish:
Service Allocation: Provider: