LAKES DISTRICT HEALTH BOARD

Lakes NASC – Referral for Short Term Services

PO Box 3023
ROTORUA
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CLIENT DETAILS (referrer to complete)

Date of Referral:	
Admission Date:	Discharge Date:
Name of Client:	
Date of Birth:	NHI Number:
Home Address:	
Home Phone:	Cell Phone:
Community Services Card Number:	Expiry Date:
Name of GP:	
Diagnosis / Disability:	

Citizenship : ☐ NZ Citizen ☐ Residency
If *residency* ticked, was evidence sighted? ☐ Yes ☐ No

Ethnicity: ☐ NZ European ☐ NZ Maori ☐ Pacific Islander ☐ Other _____

Contact Person/NOK:		Relationship:	
Address:		Contact Phone:	

WHAT DOES THE CLIENT NEED HELP WITH? (tick all boxes that apply)

Household Tasks	Personal Care	Mobility Needs	Cognitive
☐ Housework	☐ Bathing / Showering	☐ Independent	☐ Memory Impaired
☐ Safety/Security	☐ Dressing / Grooming	☐ Uses Walking Aids	☐ Behavioral Problems
☐ Other _____	☐ Medication oversight	☐ Needs Supervision	☐ Sleeping Difficulty
Sensory	☐ Eating / Drinking	☐ Needs Assistance	☐ Communication Problems
☐ Vision Loss	☐ Toileting	☐ Help To Transfer	
☐ Hearing Loss	☐ Incontinence Type:	☐ Wandering Day or Night?	

Other Services Involved			
☐ District Nurse	☐ Cardiac Nurse	☐ Respiratory Nurse	☐ Physio
☐ Diabetes Nurse	☐ Mental Health	☐ Social Worker	☐ Occupational Therapist

Social Factors			
☐ Lives in Rural Area	☐ Family Support	☐ Lives Alone	☐ Other Support

Any further comments:

Referred By:	Designation:
Contact number:	