Age Concern Canterbury He Manaakitanga Kaumātua

*Serving the needs of older people*

# Community Health Team Client Referral Form

**Referral Date:** _____ **Referred by:** _____

**Designation:** _____ **Telephone:** _____

**Email:** _____ **Mobile:** _____

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**Client's Details** **NHI**: _____

**Name**: (Mr/Mrs/Miss/Ms) _____

**Address:** _____

**Telephone:** _____ **Mobile:** _____

**Date of Birth:** _____ **Age:** _____

**Email** *(if applicable)*: _____

**Ethnicity:** _____ **IWI** (Maori): _____

**GP Name:** _____

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**Next of Kin:** _____ **Relationship to:** _____

**Contact Details of Next of Kin:** _____

**Email** *(if applicable)*: _____

**Family or Significant Other:** _____

**Reason for Referral:** _____

_____

_____

_____

_____

**Is the Client/Support person aware of referral?** **Yes** **No**

**Health Status:** _____

**Other services involved** *(eg. District Nurse, CREST, Meals-on-Wheels, Home Help)* **and provider:**

_____

**Any other comments:** _____

_____

**PLEASE RETURN THIS FORM TO: Social Network Service, Age Concern Canterbury, 24 Main North, Papanui, Christchurch 8053. Or you can fax the form to (03) 365-0639.**

*For Office Use Only:*
*Caseworker:* _____ *Date:* _____ *EANPS:* _____