WHAKATANE: P O BOX 241
PHONE 07 306-0986 FAX: 306-3073
ROTORUA P O BOX 1858
PHONE: 07-349-4213 FAX: 349-3555
TAURANGA: P O BOX 2121
PHONE: 07 571-0093 FAX: 07 571-0277
AFTER HOURS EMERGENCY FREE PHONE 0800 262477
Email: **SupportNetBOP@bopdhb.govt.nz**

Referral for Needs Assessment for People with Long-Term Disabilities (six months or longer)

Title:* Surname: First Name(s): NHI No:
***Residential Address: Preferred Name:**
***Phone: ( ) Alternative Phone ( ) Fax ( )**
***Date of Birth: Community Card No: *00000* Expiry Date:**
Communication Requirements (if any): Ethnicity:
***Usual General Practitioner: GP's Phone: ( )**
Client's Preferred Contact Person – Name: Phone: ( )
Address: Relationship:
Indicate if correspondence is to be sent to: ☐ Client, ☐ Contact Person, **or Other - provide name and address of other:**

***Nature of Disability /*Reason for Referral (please describe all difficulties and attach all relevant information and clinical assessments to this form, use extra sheet if necessary):**		
Medical Diagnosis (if any):		
Has the client been discharged from hospital in the last six weeks?	☐ **Yes**	☐ **No**
Is this referral a result of an accident?	☐ **Yes**	☐ **No**
Is the client receiving Hospice services?	☐ **Yes**	☐ **No**
Is the client receiving any other DHB-funded service?	☐ **Yes**	☐ **No**
Does the client live alone?	☐ **Yes**	☐ **No**
Does the client agree to the referral?	☐ **Yes**	☐ **No**
Does the contact person agree to the referral?	☐ **Yes**	☐ **No**

Referrer Name: Relationship:
Address: Organisation:
Phone: ( ) Alternative Phone ( )
Date: 13 June 2013 Signature:

Referrals that do not contain relevant information will be returned to referrer