Complex Clinical Care Network
TAUWHIRO

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERRAL FOR SUPPORT SERVICES

☐ **Clinical Assessor**	☐ **Dementia Outreach Nurse**	☐ **Gerontology Nurse Specialist**

Client Details (or attach patient label):

☐ Male ☐ Female ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Last Name		NHI	
First Name(s)		DOB	
Address		CS Card Number	
		Expiry Date	
		GP	
Phone		Ethnicity / Iwi	
☐ Lives Alone ☐ Lives with Others		Maori Needs Assessor Preferred ☐	

Next of Kin / Caregiver Contact Details:

Name		Relationship to Client	
Phone		Address	

Medical conditions or disabilities:	**ACC Claim Registered:** ☐ **Yes** ☐ **No**
Reason for Referral:	**Current level of daily function:** **Current level of cognition:**

Known Risks:

Action/ intervention taken:

Referral priority:	**This referral is for the following service(s):**
☐ Difficulty managing household tasks only ☐ Routine	☐ Short term services ☐ Long term services
☐ Urgent (reason):	☐ **Short/long term services already in place?** Expiry date:

Other health professionals involved:	**Other information / Alerts:**

Choice of provider: ☐ **Access** ☐ **Coasters**

Referrers Details (please print clearly):

Name		Consent for referral given by disabled person / carer ☐ Yes ☐ No. If "No" why?:
Designation		
Organisation		
Address		Send to Complex Clinical Care Network: PO Box 387, Greymouth **Fax: 03 768-9625** Ph: 03 768-0481 Email: care.link@westcoastdhb.health.nz
Signature		
Phone		
Date		