Age Concern Waikato, Community Navigation

Client Referral Information

Criteria for Service Referral - MUST be completed before submitting:
- ☐ Is this person 65 years+?
- ☐ Has the service been explained to the person, and **have they given their permission to be referred to Age Concern?**

Client details:

Title (e.g. Mr) _____ First name:_____ Preferred name:_____

Middle name: _____ Surname: _____

Physical address**:**_____
(Unit) (Street Number) (Street name)

_____
(Suburb) (City) (Post Code)

Postal address: (if different from above):_____

_____

Home phone:_____ Mobile phone:_____

E-mail:_____

Date of birth:_____/_____/_____ Gender: Female ☐ Male ☐

DHB:_____ NHI number: (*optional*) _____

Ethnicity:

☐ Pakeha (NZ European)	☐ Maori	☐ Pacific Islander
☐ European (including British)	☐ Chinese	☐ Indian
☐ Other Asian	☐ Australian	☐ North American
☐ African ☐ Middle Eastern	☐ Latin American	☐ Unknown

Living alone? Yes ☐ No ☐ Rest home resident? Yes ☐ No ☐

Next of kin / Emergency Contact: Name: _____

Phone: _____Relationship: _____

Client situation:

Reason for referral: _____

Other services client receives: _____

_____

Health/mobility issues: _____

Identified hazards: (please tick any hazards that may pose a risk to AVS workers, and provide details)

None	☐
Animals	☐
Client behaviour	☐
Family of client	☐
Hygiene	☐
Maintenance	☐
Neighbourhood	☐
Smoking	☐
Other	☐

Details: _____

Referrer's details:

Name: _____ Position _____

Organisation: _____

Phone: _____ E-mail: _____

Return referral form to:

Community Navigation
Age Concern Waikato
150 Grantham Street, Hamilton 3204
E: enquiries@ageconcernwaikato.org.nz

Administration Use: