Age Concern Waikato Social Connection

Client Referral Information

Criteria for Service Referral - MUST be completed before submitting:

- ☐ Is this person 65 years+?
- ☐ Is the person at risk of social isolation due to having no or very few visitors?
- ☐ Is this person living in the community?
- ☐ Is the person able to contribute to a mutually beneficial friendship relationship?
- ☐ Has the service been explained to the person, and have they given their permission to be referred to Age Concern?

Client details:

Title: Mr. Mrs. Ms. Miss. (Please Circle)

First name: _____ Surname: _____
Preferred name: _____
Physical address**:** _____
Postal address: (if different from above): _____
Home phone: _____ Mobile: _____
E-mail: _____
Date of birth: _____ Gender: Female ☐ Male ☐
DHB: _____ NHI number: _____

Ethnicity:

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

Client Interests & Hobbies:

_____
_____
_____

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: _____
_____
_____

Mobility issues: _____

Identified hazards: (please tick any hazards that may pose a risk to 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:

Social Connector, Age Concern Waikato
150 Grantham Street, Hamilton 3204
E:Hamilton avs@ageconcernwaikato.org.nz **E:** Rural rural@ageconcernwaikato.org.nz

Administration Use:

Initial Visit On: _____Initial Visit With: _____
Matched With: _____

NDB: ☐ Client ID: _____