

Received:	
Accepted:	
Waiting List:	
Acknowledgment:	
File No:	
Assessment No:	
Note:	

Referral Form

1. CLIENT DETAILS:

Surname: _____

Preferred name: _____

Address: _____

First names: _____

Title: Mr Mrs Miss Ms Other

Gender: M F DOB: _____

NHI number: _____ NHI Number is required. It can be obtained from your GP

Ph: (H) _____ Ph: (M) _____

Fax: _____ Ph: (W) _____

Email: _____

Ethnicity (required by the ministry of health)

Maori – tribal affiliation: _____ New Zealand European

Pacific Island (please specify) _____ Other (please specify) _____

Do you have New Zealand Residency? No Yes

2. PARENT/CAREGIVER : (If applicable)

Name: _____ Ph: (H) _____ Ph: (M) _____

Address: (if different from above) _____ Fax: _____ Ph: (W) _____

Email: _____

Relationship to person referred _____

3. PERSON MAKING REFERRAL: If different from 1 or 2 above (e.g. therapist)

Name: _____ Ph: (H) _____ Ph: (M) _____

Address: _____ Fax: _____ Ph: (W) _____

Email: _____

Relationship to person referred _____

4. ARE YOU ELIGIBLE FOR ACC ASSISTANCE IN RELATION TO THIS REFERRAL?

No (go to question 5) Yes (please provide the following details)

ACC Case Manager: _____ Ph: _____

ACC Client Number: _____ Email: _____

ACC Branch Office: _____

5. DO YOU RECEIVE IDEA SERVICES?

No Yes If yes, please check IDEA policy before completing this referral.

Both the IDEA Regional SLT and Area Manager need to "sign off" this referral before it can be accepted by TalkLink Trust.

6. HAVE YOU BEEN SEEN BY A NEEDS ASSESSMENT SERVICE CO-ORDINATION (NASC)?

No (go to question 7) Yes (please provide the following details)

Name of Service: _____ Ph: _____
Contact Person: _____ Fax: _____
Email: _____

7. CLINICAL DIAGNOSIS/DISABILITY: Information about your disability relevant to this referral

8. REASON FOR THE REFERRAL:

Do you have difficulties with any of the following? Please describe.

Speech? No Yes _____
Writing? No Yes _____
Computer/Keyboard/Mouse? No Yes _____
Telephone? No Yes _____
Other technology? No Yes _____

9. EXPECTATIONS FROM THIS REFERRAL:

10. CONTACT DETAILS FOR PROFESSIONALS:

Please provide details for any professionals with whom you have had contact regarding communication difficulties. (For example: vision or hearing specialist, physiotherapist, SENCO, teacher, psychologist, GP/specialist, neuropsychologist etc).

Name	Profession	Phone/Email
	Speech-Language Therapist	
	Occupational Therapist	

11. DO YOU ATTEND AN EDUCATION FACILITY?

No Yes (If yes, please provide details)

Name of Facility: _____ Ph: _____
Contact person: _____ Role: _____ Email: _____

12. SAFETY

Please provide detail of any potential risks in regards to personal safety with visiting the person at home (e.g. access, dogs, medical, etc?)

13. CONSENT (to be completed by the person referred or their parent/guardian)

- a) For the purposes of this assessment, I permit staff from TalkLink to obtain information from professionals or other individuals as provided above.
- b) I consent to the processing of this referral.

By typing your name here you are 'electronically signing' this form. A copy of your email and form will be kept for our records.

NAME: (print) _____ **Relationship to client:** _____

SIGNED/TYPED: _____ **Dated:** _____

TalkLink Trust

Please submit the completed referral to your closest regional office:

UPPER NORTH ISLAND

auckland@talklink.org.nz
Telephone: (09) 815 3232 Fax: (09) 815 3230
PO Box 44 053, Pt Chevalier, Auckland 1246, New Zealand

LOWER NORTH ISLAND

wellington@talklink.org.nz
Telephone: (04) 381 4956 Fax: (04) 381 4958
PO Box 24 070, Wellington 6011, New Zealand

SOUTH ISLAND

south@talklink.org.nz
Telephone: (03) 374 9222 Fax: (03) 379 5939
PO Box 32 074, Christchurch 8011, New Zealand

If you have any enquiries, please call: **0800 825 554**