**Referral Form**

**Section 1: Personal Information**

* **Name (First & Last):**
* **Title (Mr/Mrs/Ms/etc.):**
* **Preferred Name:**
* **Address:**
* **Contact Number:**
* **Email:**
* **Preferred Contact Method:**
* **Date of Birth:** DD/MM/YYYY
* **Gender:**
* **Pronoun:**
* **Residency Status:**
* **Ethnicity:**
* **Iwi / Hapū (if Māori):**
* **First Language (if not English):**
* **Interpreter Required:**
* **Cultural Support Required:**
* **Communication Needs:**

**Section 2: Medical Information**

* **Doctor/GP Name:**
* **Medical Centre Address:**
* **Medical Centre Contact Number:**
* **National Health Index (NHI) Number:**
* **Attach Confirmation of Diagnosis Form:** [Upload]

**Section 3: Disability Information**

* **Disability Name/Type:**
* **Other Medical/Health Issues (if any):**
* **Reason for Referral:**
* **Supports/Services Desired:**
  + Information about services and supports
  + Connection with services and support
  + Development of a Living Well Plan
  + Unsure
* **Urgency of Services/Supports Needed:**
  + Urgent (within 2 days)
  + Semi-urgent (within 1 week)
  + Non-urgent

**Section 4: Additional Information**

* **Safety, Hazards, or Sensitive Issues:**
* **Other Important Information:**

**Section 5: Alternative Contact (Optional)**

* **Name (First & Last):**
* **Contact Number:**
* **Email:**
* **Relationship to the Person Referred:**

**Section 6: Referrer’s Contact Details**

* **Name (First & Last):**
* **Contact Number:**
* **Email:**
* **Relationship to the Person Referred:**

**Section 7: Consent and Privacy**

* **Consent to Provide Information:** I Agree
* **Consent to Share Information for Assessment:** I Agree
* **Consent to Be Contacted for Verification/Additional Information:** I Agree
* **Consent for Statistical Reporting:** I Agree
* **Right to Access/Correct Provided Information:** I Agree

**Section 8: Signatory**

* **Signature Method:** Digital Signature / Text Input
* **Name of Parent/Guardian (if on behalf of a child):**
* **Date:** DD/MM/YYYY