**Referral Form**

**Section 1: Personal Information**

* **Name (First & Last):** John Doe
* **Title (Mr/Mrs/Ms/etc.):** Mr.
* **Preferred Name:** John
* **Address:** 123 Example Street, Sampleville, Region, 12345
* **Contact Number:** 021 123 4567
* **Email:** john.doe@example.com
* **Preferred Contact Method:** Phone
* **Date of Birth:** 14/08/2004
* **Gender:** Male
* **Pronoun:** He
* **Residency Status:** NZ Citizen
* **Ethnicity:** NZ European
* **Iwi / Hapū (if Māori):** N/A
* **First Language (if not English):** N/A
* **Interpreter Required:** No
* **Cultural Support Required:** No
* **Communication Needs:** Yes, Non-verbal communication (requires anticipation and support)

**Section 2: Medical Information**

* **Doctor/GP Name:** Dr. Jane Carter
* **Medical Centre Address:** 456 Health Avenue, Sampleville, Region
* **Medical Centre Contact Number:** 09 123 4567
* **National Health Index (NHI) Number:** XYZ1234
* **Attach Confirmation of Diagnosis Form:** [Upload] (Assumed completed by Dr. Carter)

**Section 3: Disability Information**

* **Disability Name/Type:** Autism Spectrum Disorder, Intellectual Disability (pending documents), Developmental delay
* **Other Medical/Health Issues (if any):** Sleep disturbances, Sensory processing issues
* **Reason for Referral:** Ongoing support for managing daily living, behavior, and safety concerns.
* **Supports/Services Desired:**
  + Information about services and supports
  + Connection with services and support
  + Development of a Living Well Plan
* **Urgency of Services/Supports Needed:** Semi-urgent (required within one week)

**Section 4: Additional Information**

* **Safety, Hazards, or Sensitive Issues:** John has a tendency to wander off and has no understanding of road safety; requires constant supervision.
* **Other Important Information:** John requires a high level of support for daily living tasks, including personal care, communication, and mobility.

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

* **Name (First & Last):** Jane Smith
* **Contact Number:** 021 987 654
* **Email:** jane.smith@example.com
* **Relationship to the Person Referred:** Mother

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

* **Name (First & Last):** Jane Smith
* **Contact Number:** 021 987 654
* **Email:** jane.smith@example.com
* **Relationship to the Person Referred:** Mother

**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
* **Name of Parent/Guardian (if on behalf of a child):** Jane Smith
* **Date:** 15/10/2023