NorthAble
DISABILITY SERVICES

40 John Street
Whangarei
Email: drc@northable.org.nz

Telephone: (09) 430-0988
Fax: (09) 438-9468
Freephone: 0508-637-200

Needs Assessment & Service Coordination Referral Form

Individually based on the following criteria: Aged 0-65 and who have been identified as having a Physical, Sensory or Intellectual disability or a Combination of these, not based on a Personal or Medical Health diagnosis,
which is likely to continue for a minimum of six months and result in a reduction of independent functioning to the extent that ongoing support is required

Please ensure that this referral has **ALL AREAS** completed!

*If the Person is already a Client of NASC a Referral Form **DOES NOT NEED TO BE COMPLETED.** The NASC can be contacted directly to look at any change in support needs.*

The person you are referring to our service (or their Carer) **MUST CONSENT** to the referral.

Please indicate that you have gained their consent by checking this box. Consent Given ☐

The person being referred (or their Carer) **GIVES PERMISSION** for NorthAble NASC to request further information from any agency that the person is involved with, (e.g. Health Professional, Government Agency, Educational Facility, Social Services etc), for the purpose of assisting in the determination of eligibility and/or in the determining of any future supports.

Signature of person being referred (or their Carer)
Or
Signature of person referring (on behalf having gained consent)

Agency Making Referral

Person Making Referral

Postal Address Of Agency or Person Making Referral
(NOTE: If address is not completed a letter of acknowledgement will not be sent)

Phone Number Of Referrer

Date of Referral

Preference of Needs Assessor Maori ☐ Non Maori ☐ No Preference ☐

Client Information

Client Name

NHI

Gender

Date of Birth

Ethnicity

Iwi

Hapu

Home Address

Mailing Address
(if different from above)

Home Phone number Mobile Number

Work Number

Alternative or Emergency Contact *– this is who we will contact if we cannot contact the person being referred*

Name of Alternative or Emergency Person

Relationship to Client

Home Phone Number Mobile Number

Work Number

GP's Name
Phone Number
Specialist/Paediatrician Name
Phone Number

Diagnosis **- (SUPPORTING DOCUMENTATION / REPORTS FROM GP/SPECIALIST/S ARE REQUIRED - PLEASE ATTACH)**

Disabling Effects **- (PLEASE DESCRIBE DISABILING EFFECT OF DIAGNOSIS AND REDUCTION IN FUNCTION)**

Specific Disability Support/s – What may be required and why? **- (PLEASE SPECIFY)**

Priority (in your opinion) High ☐ Medium ☐ Low ☐

Mental Illness Present Yes ☐ No ☐ Unknown ☐

Is this Person Receiving Services? Yes ☐ No ☐ Unknown ☐

If **YES** **(PLEASE SPECIFY)**

Client Receiving ACC Yes ☐ No ☐ Unknown ☐

Is this Person Receiving Services? Yes ☐ No ☐ Unknown ☐

If **YES** **(PLEASE SPECIFY)**

To Your Knowledge Possible Safety and Hazard Issues for visiting Needs Assessor
(ENTER IF KNOWN eg: DOGS, ENVIRONMENT, ACCESS TO HOME, ETC)

FOR THE BEST OUTCOME ENSURE YOU HAVE COMPLETED:

- **REFERRER'S NAME, POSTAL ADDRESS & PHONE NUMBER**
- **CLIENT (OR CARER) CONSENT HAS BEEN GAINED**
- **DOCUMENTATION FROM GP/SPECIALIST ATTACHED**
- **DIAGNOSIS / DISCRIPTORS AND RECOMMENDATIONS**
- **IDENTIFIED SAFETY and HARZARDS**

PLEASE NOTE: ALL AREAS MUST BE COMPLETED

Incomplete information may cause delays in the processing of your referral or a decline.