

Received:	
Accepted:	
Waiting List:	
Note:	

1. CLIENT DETAILS:

Surname: _____ First names: _____

Preferred name: _____ Title: Mr Mrs Miss Ms Other _____

Address: _____ Gender: M F Date of Birth: _____

NHI number (Please obtain from your GP) _____

Phone (Home): _____ Mobile: _____

Email: _____ Phone (Work): _____ Fax: _____

Preferred Contact Method:
 Email Phone Mobile Text Letter Other (please specify) _____

Ethnicity (required by The Ministry of Health)

Maori – tribal affiliation: _____ New Zealand European

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

Would you like the tautoko/support of a Maori Liaison person? No Yes

Do you have New Zealand Residency? No Yes

Do you require an interpreter? No Yes Language: _____

2. PARENT/CAREGIVER : (If applicable)

Name: _____ Phone (Home): _____ Mobile: _____

Address: (if different from above) _____ Phone (Work): _____ Fax: _____

Email: _____

Relationship to person referred _____

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

Name: _____ Phone (Home): _____ Mobile: _____

Address: (if different from above) _____ Phone (Work): _____ Fax: _____

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: _____ Phone: _____

ACC Client Number: _____ Email: _____

ACC Branch Office: _____

5. 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: _____

Phone: _____

Contact Person: _____

Fax: _____

Email: _____

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

Please attach any relevant reports. Please continue on a separate sheet if necessary.

7. REASON FOR THE REFERRAL?: Please Ticka. **Assessment/Consultation:** b. **Re-assessment (previously seen by TalkLink):** c. **Training:** Would you like to receive details of TalkLink courses? No Yes**8. WHAT WOULD YOU LIKE TO GAIN FROM THIS REFERRAL?:**

e.g. Support with existing equipment, implementation of a communication system, assistance to move from low tech to high tech equipment, allow access to computer etc. Please continue on a separate sheet if necessary.

9. PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT YOUR CURRENT COMMUNICATION:

If this referral is for assistance with communication, please comment on language level (what can be expressed/understood), degree of speech clarity, if there is an alternative communication system in place, how much opportunity there is to communicate in a day and who with, and why the current system is not working. Please continue on a separate sheet if necessary.

10. MOBILITY / PHYSICAL / SENSORY NEEDS:

Please comment on current function, gross and fine motor movements including wheelchair use and any sensory impairment.

11. CONTACT DETAILS FOR PROFESSIONALS:

Please provide details for any professionals with whom you have had recent contact.

(For example: vision or hearing specialist, physiotherapist, SENCO, teacher, psychologist, GP/specialist, neuropsychologist etc).

Name	Profession	Phone/Email
	Speech-Language Therapist	
	Occupational Therapist	

12. DO YOU ATTEND AN EDUCATION FACILITY OR ARE YOU IN EMPLOYMENT (PAID OR VOLUNTARY)?

No Yes (If yes, please provide details)

Facility/Work Name: _____ Role: _____

Contact person: _____ Ph: _____ Email: _____

13. 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?)

14. 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: _____

Please email the completed form to:

referrals@talklink.org.nz

TalkLink Trust
www.talklink.org.nz

or post to:

TalkLink Trust - Northern

PO Box 44 053
Pt Chevalier
Auckland 1246

TalkLink Trust - Central

PO Box 24 070
Wellington 6142

TalkLink Trust – South Island

PO Box 10204
Christchurch 8145

Acknowledgement of your referral being received will be provided during processing.