TalkLink
Wahanga Tu Korero
Assistive Technology Services

Referral Form

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. 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: _____ **Phone:** _____

Contact Person: _____ **Fax:** _____

Email: _____

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

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

8. REASON FOR THE REFERRAL?: *Please Tick*

a. Assessment/Consultation: ☐

b. Re-assessment (previously seen by TalkLink): ☐

c. Training: ☐

Would you like to receive details of TalkLink courses? ☐ **No** ☐ **Yes**

9. 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.

10. 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.

11. MOBILITY / PHYSICAL / SENSORY NEEDS:

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

12. 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	

13. 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:** _____

14. 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?)

15. 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 submit the completed referral to your closest regional office.
Acknowledgement of this being received will be provided during processing.

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