**AgeConnect Referral Form**

First names:

Preferred Name:

Last Name:

Address:

Postcode:

Home Phone:

Cell Phone:

Email:

Date of birth:

NHI Number:

General Practitioner:

**Statistical Details**

Gender: ❑ Female ❑ Male ❑ Other

Ethnicity:

 ❑ Pākehā (NZ European)

 ❑ Māori

 ❑ Pacific Islander

 ❑ European

 ❑ Chinese

 ❑ Indian

 ❑ Other Asian - Indonesian

 ❑ Australian

 ❑ North America

 ❑ African

 ❑ Middle East

 ❑ South America

 ❑ Britain/Scotland/Ireland

 ❑ Other

**Client Contact Details**

**Client Individual Details**

Retirement Village Resident: Yes ❑ No ❑

Living in the community: Yes ❑ No ❑

Living Alone Yes ❑ No ❑

NZ Citizen/Residency: Yes ❑ No ❑

**Next of Kin / Emergency Contact Details – no family in New Zealand**

Names: ………………………………………………………………………………………………………

Phone: ………………………Cell: Relationship: ……………………………..

Turn page

**Community assistance currently being received** (Tick all that are relevant)

❑ a. Home support services - personal care, household management, Meals on Wheels, medical alarm

❑ b. Social support services e.g. R.S.A., Senior Citizens groups, Church

❑ c. Informal supports e.g. family / neighbour / volunteers

❑ d. Mobility / transport assistance e.g. total mobility card

❑ e. Iwi social services e.g. Maori services, home or marae-based support services

❑ f. Counselling / Mental Health services e.g. psychogeriatric services, private counsellors

❑ g. Other

**Health issues the person is experiencing:** ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Issues the person needs assistance with**:

❑ a. Transport …………………………………………………………………………………………………..

❑ b. Housing ……………………………………………………………………………………………………..

❑ c. Home help ………………………………………………………………………………………….

❑ d. Social Connections ………………………………………………………………………………………..

❑ e. Other

**Additional information** – is there other information we need to know?

**Referrer’s Details**

Name: Organisation:

Day Phone: Cell Phone:

Email: Date: ………………………………

**Return Referral Form to:**

**POST:**

Age Concern Tauranga

177a Fraser Street,

Tauranga 3112

**EMAIL:**

cc.ageconcerntga@xtra.co.nz