**Text

Description automatically generated**

# Connections & Funding Referral Form / **Te Hononga me te Pūtea Puka Whakawhiti**

|  |
| --- |
| About You |

|  |  |
| --- | --- |
| Full name |  |

|  |  |
| --- | --- |
| Address |  |

|  |  |
| --- | --- |
| Telephone number |  |

|  |  |
| --- | --- |
| Email address |  |

|  |  |
| --- | --- |
| How would you like us to contact you? For example, phone, email. |  |

|  |  |
| --- | --- |
| Who is the best person to contact? |  |

|  |
| --- |
| If not the person. Name and relationship to you, how do they wish to be contacted? |

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Date of Birth |  |

|  |  |
| --- | --- |
| National Health Index (NHI) if known |  |

|  |
| --- |
| Which most closely describes your gender? |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Female |  |  |  | Male |  |  |  | Non-Binary |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Transgender Man |  |  |  | Transgender Woman |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Agender/I don’t identify with any gender |  |  |  | Prefer not to state |  |  |  |

|  |  |  |
| --- | --- | --- |
| Gender not listed. My gender is: |  |  |

|  |
| --- |
| Resident Status |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| New Zealand Citizen |  |  |  | New Zealand Resident |  |  |  |

|  |  |  |
| --- | --- | --- |
| Other |  |  |
| Ethnicity | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| European |  |  |  | Māori |  |  |  | Asian |  |  |  | Pacific peoples |  |  |  |

|  |  |  |
| --- | --- | --- |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| What language do you prefer to speak? |  |  |

|  |
| --- |
| Would you like an interpreter or cultural support? |

|  |
| --- |
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| --- |
| Who do you live with? |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Whānau|Family |  |  |  | Alone |  |  |  | Partner |  |  |  | Friends |  |  |  |

|  |
| --- |
| Medical Information |

|  |  |  |
| --- | --- | --- |
| Doctor’s Name |  |  |

|  |  |  |
| --- | --- | --- |
| Medical Centre Address |  |  |

|  |  |  |
| --- | --- | --- |
| Medical Centre Phone number (mandatory) |  |  |

|  |  |  |
| --- | --- | --- |
| Community Services Card number and expiry date |  |  |

|  |
| --- |
| Consent and Privacy Statement |

|  |  |  |  |
| --- | --- | --- | --- |
| I am filling out this form myself and I give you permission to use the information. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| I am filling out this form for someone else and have their consent. |  |  |  |

|  |
| --- |
| I am filling out this form for someone else and do not have their consent because - |

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| --- | --- | --- | --- |
| I understand you will share this information with team members and other disability providers to achieve my good life and where required by law. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| I understand I can ask for copies of all the information and if I think the information is wrong, I can ask for it to be corrected. |  |  |  |

|  |  |  |
| --- | --- | --- |
| Full name of person filling in this form |  |  |

|  |  |  |
| --- | --- | --- |
| Relationship to disabled person |  |  |

|  |  |  |
| --- | --- | --- |
| Address |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Contact email |  | Telephone number |  |

|  |
| --- |
| Disability |

|  |  |  |
| --- | --- | --- |
| My disability is |  |  |

|  |
| --- |
| I also live with these medical/mental health/accident-related conditions |

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| --- |
| If it’s the first time you have worked with us, and you have a diagnosis of intellectual or autism spectrum disorder, please attach relevant specialist reports. |

|  |
| --- |
| For all other diagnosis you can ask your doctor or specialist to fill out a ‘Confirming Eligibility for Disability Supports’ form. **Please contact us to access the form.** |

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| --- |
| Reasons for Applying |

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| --- | --- | --- |
| What is going on right now? |  |  |

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| --- | --- | --- |
| How can we assist you? |  |  |

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| --- |
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| --- | --- | --- | --- |
| Connect with services and support |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Provide information about what is available in my community |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Engage with us to develop a plan on what living well looks like for me |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Not urgent |  |  |  | Semi urgent |  |  |  | Urgent |  |  |  |

|  |
| --- |
| Describe any safety, hazards or sensitive issues that we need to know about? |

|  |
| --- |
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| --- |
| What other people or organisations are you working with? |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Specialists |  |  |  | Social Worker |  |  |  | Therapist |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Psychologist |  |  |  | Paediatrician |  |  |  | ACC |  |  |  |

|  |  |  |
| --- | --- | --- |
| Other |  |  |

|  |
| --- |
| Hospital Discharge Information |

|  |  |  |
| --- | --- | --- |
| Discharge date |  |  |

|  |
| --- |
| Is short term support in place? If yes – provide details |

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| --- |
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| --- |
| Is your home suitable for your immediate and ongoing support needs? |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Yes |  |  |  | No |  |  |  |

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| --- |
| Additional information applicable to this application |

|  |
| --- |
|  |

**Thank you for your referral. We will contact you within five working days.**

|  |  |  |
| --- | --- | --- |
| Date |  |  |