

Confirming disability

Phone: 0800 758 700 or 0508 447 6275

Email: [referrals@yourwaykiaroha.nz](mailto:referrals@yourwaykiaroha.nz)

**Who should use this form?**

Anyone who has been referred / self-referring to Your Way | Kia Roha for the first time.

The form must be completed by a doctor or specialist to confirm disability.   
Please attach it to the Your Way | Kia Roha Self-Referral or Referral Form or email it to us [referrals@yourwaykiaroha.nz](mailto:referrals@yourwaykiaroha.nz).

If you have any questions, please contact us using the details at the top of this form.

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| Section 1 - Person’s name and diagnosis |

**Full name of person being referred**

Type your answer here:

**National Health Index Number (NHI)**

Type your answer here:

**Disability diagnosis**

Type your answer here:

**Is the person’s disability ACC related** – Yes / No

Type your answer here:

**Does the person live with any other medical, mental health or accident-related conditions?**

Type your answer here:

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| Section 2 - Health professional’s details |

**Full name / s**

Type your answer here:

**Organisation**

Type your answer here:

**Signature**

Type your answer here:

**Date**

Type your answer here: