



# REFERRAL FORM

**DATE** \_\_\_\_\_

## CLIENT INFORMATION

Name: \_\_\_\_\_ Physical Address: \_\_\_\_\_

Gender: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

NHI number (if known) \_\_\_\_\_ First Language: \_\_\_\_\_

Landline: \_\_\_\_\_ Next of kin/  
guardian: \_\_\_\_\_

Cellphone: \_\_\_\_\_ GP: \_\_\_\_\_

Others involved eg family, consultant, behaviour support team  
in care: \_\_\_\_\_

Reason for  
referral:  
(Please be as specific as possible)

## REFERRER INFORMATION (IF DIFFERENT TO CLIENT):

Name: \_\_\_\_\_ Landline: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Cellphone: \_\_\_\_\_

Consent: I have gained consent from the client or their welfare guardian to make this referral: Yes / No

Cellphone: \_\_\_\_\_

## HISTORY

Diagnosis: List relevant medical or surgical history

Medications: Attach a copy of medication form where applicable

Alerts, Please list any risk factors, including management strategies  
problematic  
behaviours

Community Activities: eg day placements, work programmes, hobbies or leisure activities

## CURRENT STATUS

Mental health	<input type="checkbox"/> confused <input type="checkbox"/> anxious <input type="checkbox"/> cognitively impaired <input type="checkbox"/> mood swings <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Speech	<input type="checkbox"/> Normal <input type="checkbox"/> Confused <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid <input type="checkbox"/> Limited or non verbal <input type="checkbox"/> Uses alternative communication <input type="checkbox"/> _____
Mobility	Walking: _____ Transfers: _____ Equipment: _____ _____ Non-weight bearing: yes / no	Eyesight	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Wears glasses <input type="checkbox"/> _____
Diet	Food <input type="checkbox"/> Normal <input type="checkbox"/> Soft <input type="checkbox"/> minced <input type="checkbox"/> Puree <input type="checkbox"/> _____	Hearing:	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Wears hearing aid <input type="checkbox"/> _____ <input type="checkbox"/> _____
	Fluids <input type="checkbox"/> Normal <input type="checkbox"/> Mildly thick (grade 1) <input type="checkbox"/> Moderately thick (grade 2) <input type="checkbox"/> Extremely thick (grade 3) <input type="checkbox"/> IV Fluids Nil by mouth or tube fed: Yes / No	Height _____ Date: _____ Weight _____ Date: _____ Dentition	<input type="checkbox"/> Own teeth <input type="checkbox"/> Partial plate <input type="checkbox"/> Dentures: top / bottom <input type="checkbox"/> No teeth
Reports attached?	If yes, please list		

Please forward to: [therapyprofessionals@clear.net.nz](mailto:therapyprofessionals@clear.net.nz)