|  |
| --- |
| Criteria for Service Referral **MUST be completed** by the Referrer **before submitting** ❑ Is this person 65 years+? * Is this person at risk of social isolation due to having no, or very few social interactions?
* Is this person living in the community?
* Is this person able to contribute to a mutually beneficial relationship?
* Has the service been explained to the person?
* Has this person given their permission for the referral?
 |



**Application / Referral for Visiting Service**

|  |
| --- |
| **Statistical Details** Gender: Male / Female / LGBTQ DHB: ...................................................... Ethnicity: * Pākehā (NZ European)
* Māori
* Pacific Islander
* European (including British)
* Chinese
* Indian
* Other Asian
* Australian
* North American
* African, Middle Eastern, Latin America
* Other ................................................
 |

# Client Contact Details

First names: ......................................................

Preferred Name: ...............................................

Last Name: ........................................................

Address: ..........................................................

 ...........................................................................

 ...........................................................................

City & Postcode .................................................

Home Phone: ....................................................

Cell Phone: ......................................................

Work Phone: ......................................................

Email: ................................................................ Date of birth: .....................................................

# Client Individual Details

Rest Home Resident: Yes ❑ No ❑ Living Alone: Yes ❑ No ❑

Residency: ❑ NZ National ❑ Not a NZ National ❑ No NZ citizenship or residency

# Next of Kin / Emergency Contact Details

Names: ........................................................................................................................................ Day Phone: .................................................................... Relationship: ...................................

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**Identified Hazards** (please tick any identified)

❑None ❑ Animals ❑ Client behaviour ❑ Family of client ❑ Hygiene ❑ Maintenance ❑Neighbourhood ❑ Smoking

❑ Other - please provide details ....................................................................................................

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

❑ a. Home support services e.g. personal care, domestic assistance, “Meals on Wheels’, medical alarms

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

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

❑ d. Mobility / transport assistance e.g. taxi chits, disability parking stickers, ‘Driving Miss Daisy’

❑ 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 ............................................................................................................................................

**Issues the person is experiencing or may need assistance with** (Tick all that are relevant)

❑ a. Health e.g. physical / mental health / alcohol & drug / falls risk / self-care risk

❑ b. Transport e.g. mobility issues, needing support with transport

❑ c. Housing e.g. maintenance, heating, suitability, home/garden environment

❑ d. Social Isolation e.g. loss of community connections, loneliness, change / loss / grief

❑ e. Legal e.g. EPA, wills, advanced directives

❑ f. Finance e.g. benefits / entitlements, gambling, financial distress

❑ g. Other ............................................................................................................................................

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

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 Referrer’s Details

Name: ................................................................. Organisation .........................................................

Day Phone: ......................................................... Cell Phone: ........................................................... Email: ............................................................................................... Date: ..........................................

**Return Referral Form to:**

AVS, Age Concern Tauranga, 177a Fraser Street, Tauranga 3112 or Email: avstga@xtra.co.nz

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