PO Box 29 062

Christchurch

New Zealand

Phone: 03-365-5838

Mobile: 021-2644-183 (Manager)

Facsimile: 03-379-9403

|  |  |
| --- | --- |
| FULL NAME: | D.O.B |

|  |
| --- |
| ADDRESS: |

|  |
| --- |
| PHOTO |

|  |  |
| --- | --- |
| HOUSE MANAGER | PHONE NUMBER |

|  |  |
| --- | --- |
| SOCIAL WELFARE NUMBER |  |



|  |  |
| --- | --- |
| ETHNICITY  | GENDER |
| PHONE NO. | RELIGION |
| DATE OF REFERRAL | SNC RATING |

|  |
| --- |
| COMMUNITY SERVICES CARD NUMBER:EXPIRY DATE: |

|  |
| --- |
| ORRS NUMBER; |
| KIWIABLE CARD: |
| SCHOOL ATTENDING AND CONTACT PERSON: |

EMERGENY CONTACT

|  |
| --- |
| NEXT OF KIN:RELATIONSHIP: |
| ADDRESS: |
| PHONE NUMBER: |

SECOND CONTACT

|  |
| --- |
| NAME:RELATIONSHIP: |
| ADDRESS: |
| PHONE NUMBER: |

|  |  |
| --- | --- |
| WORKPLACEMENT  | PHONE |
|  |  |
|  |  |
|  |  |

HEALTH ISSUES

|  |
| --- |
| EPILEPSY: |
| ASTHMA: |
| DYSPHAGIA: |
| DIABETES: |
| HEART CONDITION: |
| ALLERGIES: |
| OTHER: |
| VISION: |
| HEARING: |
| INTELLECTUAL DISABILTY: |
| PHYSICAL DISABLITY: |
| HEP B STATUS: |
| DOCTOR AND CONTACT: |

|  |
| --- |
| BEHAVIOUR |

|  |
| --- |
| OTHER INFROMATION: |

|  |
| --- |
| CURRENT MEDICATION:Please attach a copy of current medications taken |

|  |
| --- |
| ALLERGIES: |
| PRN MEDICATION: |

Please attach any further relevant information with this referral.

E.G. Needs assessment, last IEP, management / crisis plan, care plan, etc.