



Date of Referral: _____ Referred By: _____

Name: _____

Address: _____

Phone Numbers: Home: _____ Mobile: _____

Email Address: _____

Date of Birth: _____ Work and Income Number: _____

Gender: Male Female Other Pronouns: _____

Doctor and Doctors Practice: _____

Cultural Identity:

Māori, Iwi/Hapū: _____

NZ European or Pākehā Samoan Cook Island Māori Tongan Niuean Chinese

Other, please print your ethnic groups: _____

Disability and Mental Health Information: (please use a separate sheet if needed)

History of Disability (diagnosis):

Mental Health Diagnosis (if any):

Contact Details:

Primary Contact Person:

Name:

Phone Numbers: Home: _____ Mobile: _____

Email Address: _____

Secondary Contact Person:

Name:

Phone Numbers: Home: _____ Mobile: _____

Email Address: _____

Health: (this information is used to keep the people who use our services safe, please provide detailed information)

Asthma: (Frequency of Attacks, date of last hospitalization)

Epilepsy: (Please describe the type, frequency, usual length of seizures and when medical assistance is required)

Diabetes: (Type of diabetes and management plan. Frequency of hyper/hypoglycemic episodes)

Allergies:

Other Medical Conditions: (high blood pressure, heart condition, hepatitis carrier, etc.)

Medications: (Please provide detailed information including names, times taken and dosages)

Goals and Plans: (Are there any Personal Plans or Paths Plans in place that we could assist with?)

Behaviours: (Please note any significant behaviours and any management plans that are in place.)

Other Relevant Information: (Likes or dislikes)

For your information:

Your information may be provided to:

- The staff of Evaro involved in providing and administering services to you.
- Outside agencies that assist us in providing and administering services.
- Ministry of Social Development and Work & Income as part of our reporting and contractual obligations.
- The Ministry of Health for health research and statistical purposes (this information is usually non-identifying).
- We will not disclose your information to any other agency unless you authorise this or we are required to do so by law.

Your right of access:

Under the Health Information Privacy Code 1994, you have the right to request access to, and correction of, any information held about you.

Declaration:

The information I have provided is true and accurate.

Signature: _____

Date: _____

OFFICE USE ONLY

- | | |
|---|--|
| <input type="checkbox"/> Referral added to CMS | <input type="checkbox"/> Weekly Plan Completed and Filed |
| <input type="checkbox"/> New File Completed | <input type="checkbox"/> Keyworker Allocated |
| <input type="checkbox"/> Added to Attendance Register | <input type="checkbox"/> Copy of Weekly Plan to Client |

Please return this form to Evaro, P.O. Box 11737, Manners Street, Wellington 6142