Please return to your nearest Age Concern Office or email to [referrals@ageconak.org.nz](mailto:referrals@ageconak.org.nz)

**Please complete all fields:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please select which service client requires:**  Counselling ☐Elder Abuse  Homeshare Social Connection Support ☐Social Work Support Storm Recovery ☐Visiting Service ☐Other*(please specify)* | | **Referral Method:** Walk in Telephone Email  Other *(please specify)* | | |
| **Client Consent** for Age Concern Auckland to contact them in future: Yes No | | |
| **Referral Date**: | | |
| **Office Only**: P1 P2 P3 | Assigned to: | | Open: | Closed: |

**Client Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  Mr /  Mrs /  Ms /  Miss | | | |
| Address: | | | |
| Suburb: | Postcode: | | Age: |
| Phone:  *Is it okay to leave a message?* Yes No | D.O.B: | | NHI: |
| Gender: M  F Other: | | |
| Residency: NZ Citizen  PR Other: | | Ethnicity/Nationality: | |
| Language spoken: | Other information: | | |
| Living Situation:  Own Home Rental  Rest Home  Homeless Other *please specify* | | | |
| Living with:  Alone Partner Family Other *please specify* | | | |

**Referral Information:**

|  |  |
| --- | --- |
| Referred By: | Organisation & Title: |
| Contact: *Phone & Email* | |
| Health condition: *Please specify if client suffers from any medical conditions* | |
| Safety Considerations: *Is there potential risk to safety for professionals doing home visits?* | |
| **Reason for Referral/Further Details** (attach additional sheets if required): *If you are a professional referring a client, please provide basic information of your own initial assessment and recommendations.* | |