Referral Form

Central and West Office: 57 Rosebank Rd, Avondale, 1026
Counties Office: 250 Puhinui Rd, Papatoetoe, 2025
Postal Address: PO Box 19542, Avondale, 1746

Please return to your nearest Age Concern Office or email to referrals@ageconak.org.nz

Please complete all fields:

Please select which service client requires: ☐ Counselling ☐ Elder Abuse Response Service ☐ Social Connections Service ☐ Visiting Service ☐ Community Social Work Service ☐ Other *(please specify)*	**Referral Method:** ☐Email ☐Telephone ☐ Walk in ☐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: ☐ Homeless ☐ Own Home ☐ Renting ☐ Rest Home ☐Other (*please specify)*		
Living with: ☐ Alone ☐ Family ☐ Partner ☐ Other (*please specify)*		
Health Condition / Medical Details: *Any known medical or health conditions?* ☐ Yes ☐ No *(If yes, please specify):*		
Safety Considerations: *Any potential safety risks for staff doing home visits? (e.g. dogs, aggression, access limitations)* ☐ Yes ☐ No *(If yes, please specify):*		

Referral Information:

Referred By:	**Organisation & Title / Relationship to Client:**
Contact Phone:	**Email:**
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.*	