Clutha Health First
Hauora Tahi Ki Iwikatea
Community Health

# Clutha Health First Community Services Referral

**Complete this Referral Form Electronically and Email to cta@chf.co.nz**

| **SERVICES REQUESTED: (Referrer to ensure a copy of this referral is provided to EACH service requested)** |
|---|
| Service: |

| **CLIENT DETAILS:** | | |
|---|---|---|
| Surname: | NHI: | |
| Given Names: | DOB: | Age: |
| Physical Address: | Ethnicity: | |
| Postal Address: | | |
| Phone (Home): | Phone (Mobile): | |
| GP: | | |

| **Is the patient suitable to conduct an appointment by Telehealth?** |
|---|
| **Is an Interpreter required?** |

| | |
|---|---|
| **Clinical Information:** | |
| **Reason for Referral:** | |
| **Date of recommended first visit:** | |
| **Other Services Involved:** | |
| **Is the patient aware of referral?** | |
| **Social Situation:** | |
| **Cultural/Religious Considerations:** | |
| **Medical Alerts:** | |
| **Safety Alerts:** | |

| **ACC:** | |
|---|---|
| ACC: | ACC or Claim No: |
| Date of Injury: | |
| ACC Injury Description: | |

| **NOK/CAREGIVER/CLIENT'S SUPPORT:** | |
|---|---|
| Full Name: | Home Phone |
| Address: | Mobile Phone |
| Relationship: | Is support person required at assessments? |

| | | |
|---|---|---|
| Referrer: | Designation: | |
| Signature: | Date: | Phone: |