

CLIENT - ADULT COMMUNITY SUPPORT REFERRAL FORM SOUTHLAND

Date Effective **21/01/2015**

Referral to: Adult Community Support, Southland Date of referral:		
Client's Name:	Date of Birth:	
Address:		
Contact Number:	WINZ No.:	
Legal Status:		
Reason for referral:		
DHB Community Mental Health/PHO Brief Interverson (e.g. RN, OT, Social Worker):	vention Service Team Contact	
Consultant:		
GP:		
Other Service Providers:		
Diagnosis:		
Other Comments (e.g. specific need identified	•	
Indicate any concerns that may impact on sup		
others' safety (e.g. Hep B, history of violence, e	.tc);	
Please include copies of any Risk Assessment/R documentation. This is necessary.	Risk Management	
Indicate client's preferred support worker:	□ Female □ Male	



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Referring Agency:	Date:	
Referrer's Name:	Signature:	
Contact details:		
Needs assessment report completed by		
Date of Assessment:		
Current Needs Assessment Attached:	□yes □no	
Prospective clients to complete:		
l am aware of and agree with referral		
Client signature		
A referral does not constitute acceptar contacted with a response from Pact.	nce into Pact services. You will be	
Please note: all referrals lapse after one year from date of referral and a new referral is needed for support to continue		

Please mail or deliver this referral to:

Pact Southland Southland Centre Manager - Sunil Castilino PO Box 280 / 15 The Crescent INVERCARGILL

Phone 03 2112850 or 0272750333

Fax 03 218 1025