Taikura Trust referral form

If you, or someone you know, needs support because of a disability, the first step is to get a needs assessment from us.

To get started, we require specific information including a confirmed diagnosis from a healthcare provider and current health documentation.

It's important you gather as much information as you can before sending a referral, so we can process your application as soon as possible.

Referral information

Who is making this referral

I'm making this referral for myself

I'm a family/whanau member making this referral for someone else

I'm a health professional making this referral for a client

Other

If this referral is not for yourself, please provide your name and contact details (including address, email, phone number or organisation if applicable)

The person referred gives permission for Taikura Trust to request further information from any other agency (eg health professional, educational facility, social service, etc), to help us decide on

their eligibility for current and future supports

Yes

No

The person referred gives consent to disclose their information, is aware of the referral and requested this service

Yes

No

Client details

Name of person requesting service (first name and family name)

Date of Birth (date/month/year)

Ethnic group (Eg New Zealand European, Maori, Samoan, Chinese, Indian, etc)

Iwi

Email of client

NHI number (if known)

Hapu

Phone number of client

Gender identify

Community Services Card Number (if known)

What languages do you speak

If an interpreter is required what's the preferred language

What's your preferred method of communication (text, phone or email)

Present living situation (Who are you living with? Do you live with others or by yourself?)

Disability details

The following questions will give us an idea of the disability related support you are seeking. Please answer all questions with as much detail as possible so that we can process your request. Supporting documentation, reports from GP/specialists are required - please attach them when requested.

Primary diagnosis - Please include primary diagnosis details and date of onset if applicable

Secondary diagnosis - Please outline any other medical, mental health or ACC/accident-related conditions if applicable

Relationship to client

Reason for referral - Please outline the reasons for this referral, indicating loss of function and its expected duration and how this is related to the stated disability

Health professional details

Please provide details of health professionals that are currently involved in your care

GP details - Please provide GP name and contact details

Specialist clinician - Enter name and organisation

ACC - Enter ACC claim details including case manager if applicable

Others (eg community health worker, patient navigator)

Alternative or emergency contact

This is who we will contact if we can't get in touch with you or the person being referred

Name

Phone

Email