

WELLINGTON AFTER-CARE ASSOCIATION INC.
Referral/Application

Ace House
111 Brougham Street
Mount Victoria

Note: This application form is to be filled out in consultation with the applicant.
It remains confidential to the applicant, the referring agency and the staff of
Wellington After-Care Association Inc.

Date of Referral:

Primary Contact Person:

Name:

Phone:

Address:

Secondary Contact Person:

Phone:

Phone :

Date of Birth:

Benefit No.

(Required by WINZ for our funding reports).

Cultural Identity:

NZ Maori

NZ European or Pakeha

Samoan

Cook Island Maori

Tongan

Niuean

Chinese

Australian

Other



If "other" please print your ethnic groups:

History of Disability (Diagnosis):

Mental Health Diagnosis (if any):

Epilepsy: (Please describe the type, frequency, usual length of seizures and when medical assistance is required)

Diabetes: (Type of diabetes and how well managed. Frequency of hyper/hypoglycaemic episodes)

Allergies:

PLEASE TURN OVER:

Other Medical Conditions: (e.g. asthma, high blood pressure, heart condition, hepatitis carrier)

Medication: (Dosage and time taken?)

Self administered: Yes/No

Date of last tetanus injection:

Mode of Transport: (to and from Ace House)

Reason for Referral:

What do you hope to gain from attending Ace House:

Other Relevant Information:

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OFFICE USE ONLY

- | | |
|--|---|
| <input type="checkbox"/> Disability Allowance Form Completed | <input type="checkbox"/> Details Added to Consumer List |
| <input type="checkbox"/> Weekly Plan Completed and Filed | <input type="checkbox"/> New File Completed |
| <input type="checkbox"/> Keyworker Allocated | <input type="checkbox"/> Details in Progress Notes Folder |
| <input type="checkbox"/> Added to Attendance Register | <input type="checkbox"/> Copy of Weekly Plan to Client |

Please return this form to: Ace House, 111 Brougham Street, Mount Victoria, Wellington