

Carer Support Registration Form

WILL BE RETURNED IF ALL PARTS ARE NOT FILLED IN



MANATŪ HAUORA

Private Bag 1942, Dunedin
Tel: 0800 281 222 Press 1

On completion of this form by a specialist or general practitioner then the answer to questions 1-7 must apply to the client (person with a personal health need).

Client Details

1. Family name of client		
First name of client		
Other names client is known by		
2. Date of Birth	DAY / MONTH / YEAR	NHI
3. Address (please include house number, street, suburb, town and/or city)		
4. Postal Address (if different from above)		
5. Contact Phone Number	Day ()	Night ()
6. Ethnicity details: (please tick)	NZ Maori ()	NZ European ()
	Other (please specify)	
7. Nature of illness which requires carer support allocation (ie, diagnosis) defined as a condition, affecting organs or systems of the body, which causes prolonged ill health		
	Has this client been referred for specialist review? Y / N	
	Has the client ever been admitted to hospital for this condition? Y / N	
	Please confirm that carer support is required for a personal health need only	

Details of Medical Assessment

(to be completed by the doctor, please print clearly)

Doctor's Name	
Organisation	
Postal Address	
Contact Phone Number	Day ()

Full Time Carer Details

1. Family name of full time carer	
2. First name of full time carer	
3. Address	
4. Date of Birth	DAY / MONTH / YEAR NHI

DECLARATION

By my signature I confirm that
(i) To the best of my knowledge the information contained on this form is true and correct and
(ii) I have read the "Carer Support – Eligibility" section overleaf and the client meets the eligibility requirements

I certify that (name of person with personal health needs as above)

Requires carer support for (number of days up to 28 days)

days for one year from this date: DAY / MONTH / YEAR

Signature of doctor

To be signed by a person over the age of 16 years, or by a representative completing the form on the client's behalf. (ie, full time carer)
I have read and understood the statement overleaf and declare that the information I have given is true and complete.
I consent to the information being used as described overleaf.

Signature

Date DAY / MONTH / YEAR

(signature of person with personal health need or representative)

MINISTRY OF HEALTH