



**ST LUKE'S CENTRE INCORPORATED  
REFERRAL FORM**

Venue: Sydenham Bowling Club, 230 Brougham Street, Christchurch Central  
Phone: 03-366 9159

| MEMBER INFORMATION   |  |               |  |
|--|--|---------------|--|
| Name   |  | NHI Number    |  |
| Address  |  | Gender        |  |
|  |  | Date of Birth |  |
| Phone  |  | Ethnicity     |  |
|  |  | Iwi           |  |
| Cell Phone   |  | Email         |  |
| CLINICAL SUPPORT INFORMATION   |  |               |  |
| Case Manager (CM) Name   |  | CM Phone      |  |
|  |  |               |  |
| CM Service   |  | CM Cell Phone |  |
| General Practitioner   |  | GP Practice   |  |
| REFERRER INFORMATION (complete if not CM)  |  |               |  |
| Name   |  | Service       |  |
| Phone  |  | Cell Phone    |  |
| Reason for Referral be specific)   |  |               |  |
| Please specify any interests   |  |               |  |
| RELEVANT HEALTH / RISK INFORMATION   |  |               |  |
| Mental health diagnosis (Please circle)  | Yes / No   | Please State: |  |
| Physical concerns:   |  |               |  |
| Any risks? Dietary requirements:   |  |               |  |
| Dietary requirements:  |  |               |  |
| Allergies:   |  |               |  |
|  |  |               |  |
| WHICH SESSIONS WILL MEMBER ATTEND? (Please circle)    Monday    Tuesday    Wednesday    Thursday   |  |               |  |
| MEMBER'S CONSENT   |  |               |  |
| <p>I, <b>Consent</b> to be referred to <b>St Luke's Centre Incorporated</b> and for the intake co-ordinator to contact my Case Manager to discuss issues that will assist St Luke's Centre to work effectively and safely with me.</p> |  |               |  |
| Signed by Member _____   |  | Date _____    |  |
| Please return to St Luke's Centre via the following options:   |  |               |  |
| • Hand in to Session Coordinators  |  |               |  |
| • Email to Erica Nisbett (Intake Coordinator)  | <a href="mailto:e.nisbett@comcare.org.nz">e.nisbett@comcare.org.nz</a> |               |  |
| • Post to Erica Nisbett (Intake Coordinator)   | Comcare Trust, P O Box 22004, Christchurch 8140                        |               |  |
| For Office Use only:   | Date Received:   | By Whom:      |  |
| Date Entered into iCIM:  |  |               |  |