



ST LUKE'S CENTRE INCORPORATED

REFERRAL FORM

Venue: Christchurch Bowling Club, 237 Worcester Street, Christchurch Central

Phone: 03 379 5218

MEMBER INFORMATION	
Name	NHI Number
Address	Gender
	Date of Birth
	Ethnicity
Phone	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
	Allergies
WHICH SESSIONS WILL MEMBER ATTEND? (Please circle)	
Monday	Tuesday
Wednesday	Thursday
MEMBER'S CONSENT	
<p>I CONSENT to be referred to St Luke's Centre Incorporated 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 Co-ordinators	
- Email to Noel McMecking (Intake Co-ordinator)	n.mcmecking@comcare.org.nz
- Post to Noel McMecking (Intake Co-ordinator)	Comcare Trust, P O Box 22004, Christchurch 8140
For Office Use only: Date Received	By Whom
Date Entered into iCIM	