Carer Support Registration Form

WILL BE RETURNED IF ALL PARTS ARE NOT FILLED IN

MINISTRY OF HEALTH
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)