Carer Support Registration Form

WILL BE RETURNED IF ALL PARTS ARE NOT FILLED IN

MINISTRY OF HEALTH

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).

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

Ongoing support means that without Carer Support there would be a significant change in the client's slient Details		
1.	Family name of client	circumstances.
	First name of client	health need. The person with a personal health need must require full-time
	Other names client is known by	(3) To be eligible to receive Carer Support a person must be assessed by a doct
2.	Date of Birth months are gen	NOTE: Applicat and an analysis and analysis analysis and analysis and analysis and analysis and analysis and analysis and analysis analysis and analysis analysis analysis and analysis analysis analysis and analysis analysis analysis analysis
3.	Address (please include house number, street, suburb, town and/or city)	Statement
4.	Postal Address (if different from above)	Under the terms of the Privacy Act 1994 we are required to inform you of the P The collection of statistical information such as cender, ethnicity, and disability
		develop a clearer picture of the requirements for people with disabilities and v
5.	Contact Phone Number	Day () Night ()
6.	Ethnicity details: (please tick)	NZ Maori () NZ European ()
		Other (please specify) adming both gollons in dilicold to volkinik and takes of
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	 for such other functions as permitted under law; to allocate you a personal identification number. The information will also be provided to the Ministry to update the National Health information will be forwarded to and stored with the Ministry of Health, You
		Has this client been referred for specialist review?
		Has the client ever been admitted to hospital for this condition?
		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) and the doctor, please print clearly) and the doctor, please print clearly and the doctor		
.9	Doctor's Name	
	Organisation	A consent to the information being used as described above;
	Postal Address	
	Contact Phone Number	Day ()
Full Time Carer Details		
	Family name of full time carer	
	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.		and declare that the information I have given is true and complete.
Signature Date DAY / MONTH / YEAR		Date DAY / MONTH / YEAR
1	(signature of person with personal health need or representative)	