

# Referral Form: Return to Work Advisor Service

For hospital referral affix patient label here

**NOTE: To be eligible for this service, person needs to be under 65 and a NZ citizen or permanent resident**

**REFERRER DETAILS**

<b>Date:</b>		<b>Name of Referrer:</b>	
<b>Organisation:</b>		<b>Contact Ph/Email:</b>	
<input type="checkbox"/> GP <input type="checkbox"/> Inpatient Stroke Service <input type="checkbox"/> NASC <input type="checkbox"/> Rehabilitation Specialist <input type="checkbox"/> Social Worker <input type="checkbox"/> Community Service <input type="checkbox"/> Other – specify: _____			
<b>Contact referrer before contacting client (safety concern/additional information) <input type="checkbox"/></b>			

**CLIENT DETAILS (or as per hospital label)**

<b>Family Name:</b>		<b>First Name/s:</b>	
<b>Title:</b>	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other: _____	<b>Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse
<b>NHI Number:</b>		<b>D.O.B (dd/mm/yyyy)</b>	
<b>Ethnicity:</b>	<input type="checkbox"/> Māori <input type="checkbox"/> NZ European <input type="checkbox"/> Pacific Island <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____		
<b>Home Address:</b>			
<b>Home Phone:</b>		<b>Mobile Phone:</b>	
<b>Email Address:</b>		<b>GP/Practice:</b>	

**ADDITIONAL CLIENT CONTACT**

<b>Alternative Contact / Carer:</b>		<b>Relationship to Client:</b>	
<b>Contact Phone</b>		<b>Contact Email</b>	

**DETAILS OF STROKE / RELEVANT MEDICAL HISTORY**

<b>Date of Stroke:</b>		<b>Type of Stroke:</b>	<input type="checkbox"/> Haemorrhagic <input type="checkbox"/> Ischaemic <input type="checkbox"/> TIA
<b>Discharge Date:</b>		<b>Discharging To:</b>	<input type="checkbox"/> Home <input type="checkbox"/> Care <input type="checkbox"/> Other: _____

*Details*

**ADDITIONAL PATIENT INFORMATION / FAMILY SITUATION**

**EMPLOYMENT**

Is there a current employer holding open a job?    No     Yes

Is client on any Benefits? No  Yes  seeing MSD this week

If Yes, which Benefit(s)

Return to work support required:

Other information attached?  No  Yes – specify \_\_\_\_\_

**Please return to:**  
**Email:** [help@stroke.org.nz](mailto:help@stroke.org.nz)  
**Address:** PO Box 12-482, Thorndon, Wellington 6144  
**To discuss referral by phone:** 0800 STROKE (0800 78 76 53)

**Tips for referrers to support a successful Return to Work:**

- Encourage referral and engagement with our service as soon as possible after a stroke
- Let person/whanau know that many people have a successful return to work after a stroke
- Suggest not making any big decisions about work until they have spoken to one of our Advisors
- Provide information on driving after a stroke
- If person is not eligible for our service, consider a referral to a Community Stroke Navigator to give basic support, information and guidance