REFERRAL TO THE WELLINGTON MULTIPLE SCLEROSIS SOCIETY
MS Community Advisory Service

Email: info@mswellington.org.nz
Phone: 04 388 8127

Referral Date:

Name: _____ DOB: _____ NHI: _____

Address: _____ GP: _____

_____ Consultant: _____

Tel: _____ Key/Alternative Contact: _____

DIAGNOSIS and relevant medical history:

LIVES:
- ☐ Alone
- ☐ Spouse/Partner ……
- ☐ With family
- ☐ Residential care ……..

SERVICES INVOLVED:
- ☐ Service Coordination
- ☐ NASC
- ☐ District Nursing
- ☐ Physiotherapy
- ☐ Dietetics
- Personal care ☐
- Household management ☐
- Podiatry ☐
- Speech Therapy ☐
- Other…… ☐

MOBILITY:
- ☐ Independent
- ☐ Stick
- ☐ Crutches
- ☐ Frame
- ☐ Wheelchair
- ☐ High falls risk

SIGHT:
- ☐ Intact
- ☐ Impaired

HEARING:
- ☐ Intact
- ☐ Impaired

BLADDER:
- ☐ Continent
- ☐ Incontinent

BOWELS:
- ☐ Continent
- ☐ Incontinent

Total Mobility Assessment Yes / No / not known

COGNITION:
- ☐ Alert & rational
- ☐ Cognitive issues

LANGUAGE USES:
- ☐ English
- ☐ Other: ……
- ☐ Requires interpreter

REASON FOR REFERRAL:

REFERRED BY: _____ DESIGNATION: _____
(Print name)
ORGANISATION: _____ CONTACT: _____
Consent for referral: Yes / No