|  |  |  |  |
| --- | --- | --- | --- |
|  | **Fax** 06 946 9898  **Post** PO Box 96  Masterton  **Email** focus@wairarapa.dhb.org.nz | **Date received at FOCUS** | **Date received at Community Health** |

|  |
| --- |
| **SINGLE POINT OF ENTRY - REFERRAL FOR COMMUNITY BASED HEALTH & SUPPORT SERVICES** |

*Please ensure all details are filled in**(affix patient label here if available)*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: | | | | First Name: | | | | | | NHI: | |
| Address: | | | | Hm Phone:  Mob Phone: | | | | | | DOB: | |
| Ethnicity: | |
| GP: | | | | Female  Male | | | | | | Lives alone  Lives with others | |
| Referral ACC related?  Yes  No  ACC Number:  Date of Injury: | | | | | | | Comm Services Card?  Yes  No  CSC Number:  Date of Expiry: | | | | |
| **Next of Kin Details** | | | | | | | | | | | |
| Surname: | | | | First Name: | | | | | | Relationship to client: | |
| Address: | | | | Hm Phone:  Mob Phone: | | | | | |  | |
| **Consent for Referral** | | | | | | | | | | | |
| Does the person consent to this referral? | | | | | Yes  No | | | | | | |
| Who consents for the person if they are unable to? (Please provide documentation to confirm this role) | | | | | Parent of child (<17yrs)  Enacted EPoA  Additional Guardian  Welfare Guardian  Other (please note) | | | | | | |
| Does the person consent to gathering of further information to support this referral by referred service? | | | | | Yes  No If not, please explain why: | | | | | | |
| **Diagnosis/Disability/Brief medical history** *(for Intellectual disability, please attach copy of psychometric testing)* | | | | | | | | | | | |
| **Events leading to referral/Current concerns** | | | | | | | | | | | |
| **Referrers Priority Level:**  **URGENT**  **ROUTINE** | | | | | | | | | | | |
| ***From the following list please indicate which service is required:*** | | | | | | | | | | | |
| 1. **Referral for Community Based Health Services?** | | | | | | | | | | | |
| **Please indicate the service(s) required:** ***(Please provide supplementary information when indicated)***  **Wound Care (District Nurses)**  **Medication Administration**  **Medication Run**  (include wound management plan, (excluding IV)  Does patient have cognitive impairment?  Dressing products used, date for  Has patient been assessed by HOP CNS?  clip/suture removal) **Clinical Nurse Specialist (CNS)**  Cardiac  **Short Term Personal cares**  **IV Medication**  Continence/Stoma (not applicable if ACC patient)  Infusor  Diabetes      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Daily IV (push)  Health of Older Person (HOP)      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cellulitis Pack  Psychogeriatric  Respiratory (includes oxygen)  **Short Term Home Management (Housework)**  **Oncology**  Wound Care (not applicable if ACC patient) ***Requires CSC*** | | | | | | | | | | | |
| **DOCUMENTS List of Current medications**  **For all medicine administration** DRUG CHART  **REQUIRED Inpatient** DISCHARGE SUMMARY  **Primary Health** HEALTH SUMMARY  **Continence** *(as applicable) catheter type/size*  *MSU results* | | | | | | | | | | | |
| 1. **Referral for Palliative and/or Hospice Services?** | | | | | | | | | | | |
| **Please indicate the service(s) required: Has this been discussed with the GP? Yes  No  Has the person agreed? Yes  No**  **Kahukura Palliative Care**   **Hospice Wairarapa**  (clinical services) (support services) | | | | | | | | | | | |
| 1. **Referral for FOCUS Long Term Support Services?** (not applicable if needs are related to an injury – consider referral to ACC) | | | | | | | | | | | |
| **Please indicate the service(s) required:** *(Referrals can be made by the person or on behalf of the person with their consent)*  **Long Term Home Management**  (must have CSC)  **Long Term Personal Cares**  **Review of Services**  **Other** | | | | | | | | | | | |
| 1. **Referral for other services?** | | | | | | | | | | | |
| **Please indicate the service(s) required:**  **Social Worker**   **Physiotherapy**  **Occupational Therapy**  **Speech Language Therapy**  **Dietician**  **Orthotics**  **VNT**   **Meals on Wheels**  **Other** | | | | | | | | | | | |
| ***Please complete the sections below relevant to this referral:*** | | | | | | | | | | | |
| **Alerts/Risk Factors** | **Mobility** | **Cognition** | | | | **Bowels** | | **Hearing** | | | **Formal Support in place?**  *(FOCUS Office use only)* | |
| Dogs at home  Falls risk  Infectious  Aggressive behaviour  Safety risk  Other | Independent  Immobile  Stick  Crutches  Frame  Wheelchair  Other | Alert & rational  Mildly confused  Very confused | | | | Continent  Incontinent | | Good  Impaired | | | **Current FOCUS Client?**  Yes  No  Home management  Personal cares  Respite  Day Activities  Carer Support  Other  **Provider of HM/PCs**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Nutrition** | | | | **Bladder** | | **Sight** | | |
| Good  Poor | | | | Continent  Incontinent  Catheterised | | Good  Impaired | | |
| **Skin Integrity** | | | |
| Intact  Broken | | | |
| **Referrer Details (fill in ALL details)** | | | | | | | | | | | | |
| Name: | | | Designation: | | | | | | Date: | | | |
| Organisation/Ward/Dept: | | | Phone:  Fax: | | | | | | Signed: | | | |
| Date Admitted to Ward: | | | | | | | Date discharged from Ward: | | | | | |

**NB: WHERE THERE IS INSUFFICIENT INFORMATION TO DETERMINE THE REFERRAL OUTCOME THE REFERRAL WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE REFERRER**