FOCUS Nga Kaupapa Haua Support for people with disabilities	**Fax** 06 946 9898 **Email** focus@wairarapa.dhb.org.nz	Date received at FOCUS	Date received at Community Health

SINGLE POINT OF ENTRY - REFERRAL FOR DHB COMMUNITY HEALTH & SUPPORT SERVICES

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

ACC DETAILS (must be entered if ACC)	NHI:	DOB:
Number:	Surname:	First Name:
Date of injury:	Address:	
COMMUNITY SERVICES CARD	Phone:	GP:
(Required for Home Management)	Ethnicity:	Gender:
CSC Number:	Lives alone or with others?:	
Expiry date:	Best contact/NOK name:	
(FOCUS office use only) **FOCUS Client? Yes No** Services provided Provider of HM/PC	Address: Phone:	Relationship:

Consent for Referral

Does the person consent to this referral? **Yes** ☐ **No** ☐ Is this referral for information / palliative data only**? Yes** ☐ **No** ☐

Does the person consent to FOCUS gathering further information to support this referral? **Yes** ☐ **No** ☐

Who consents for the person if they are unable to?	Parent of child (<17yrs) ☐ Enacted EPoA ☐ Additional Guardian ☐ Welfare Guardian ☐ Other (please note) Documentation provided to confirm this role? **Yes** ☐ **No** ☐

Which service would you like to refer to?

FOCUS	COMMUNITY NURSING	CLINICAL NURSE SPECIALISTS
☐ Long term supports – personal cares, home management, support for family carers, residential care ☐ Wairarapa Palliative Care register and support in home or community – personal cares, home management, support for family carers, (e.g. day support, in home night support, short term care, residential care	☐ Short term Personal Care ☐ Home management ☐ ☐ Wound care ☐ Complex medication administration and support (medication chart required) ☐ Catheter Care ☐ Specialist Palliative Nursing service (Kahukura)	☐ Cardiac ☐ Continence/Stoma ☐ Diabetes ☐ Oncology ☐ Respiratory ☐ Wound Care
OTHER:_____		

All referrals for the palliative register, to be completed by primary care only

Is the person being referred aware of their palliative status? Yes ☐ **No** ☐

According to the Gold Standards Framework, prognosis for purpose of palliative referral prioritisation is:

☐ **Green – Months prognosis** ☐ **Amber – Weeks prognosis** ☐ **Red – Days prognosis**

Diagnosis/Disability/Brief medical history & Reason for referral

Supporting documentation attached eg. GP classification sheet, discharge summary, wound plan etc:

Alerts/Risk factors Dogs at home Y/N Falls risk Y/N Infection risk Y/N Aggressive behaviour Y/N Safety risk Y/N Other

Cognition (please choose one) Alert & rational ☐ Mildly confused ☐ Very confused ☐

Referrer Details (fill in ALL details)

Name:	Designation:	Date:
Organisation/Ward/Dept:	Phone: Fax:	Signed:
Date Admitted if a Hospital Inpatient:	Date discharged from Ward:	

NB: If insufficient information is provided, we can't action your request and will need to return your referral. Please contact us to discuss further if needed.