Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

REFERRAL FOR NEEDS ASSESSMENT FOR PEOPLE OF ALL AGES WITH LONG-TERM DISABILITIES (6 months or longer)

REFERRER DETAILS

Referrer:_____ Relationship:_____ Role: _____

Email:_____ Organisation: _____

Address: _____

Phone:_____ Alternative phone: _____

Date:_____

CLIENT DETAILS

Title:_____ Surname: _____ First name(s):_____ NHI No: _____

Residential address:_____ Preferred name:_____

Email address:_____

Phone: Alternative phone:

Date of birth: Community card No: 00000 Expiry date:

Communication requirements (if any):

Ethnicity: Iwi:

General Practice name: _____

Usual General Practitioner: GP's phone:

Client's Preferred Contact Person – Name: _____ Phone:_____

Email address: _____

Address: _____ Relationship:_____

Indicate if correspondence is to be sent to: ☐ Client ☐ Contact person Via: ☐ Email ☐ Post

or Other - provide name and address of other:

Medical Diagnoses / Disability	**Impact of Diagnosis on Daily Living**

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TO ASSIST WITH TRIAGING - PLEASE ANSWER ALL QUESTIONS

Does the client / Welfare Guardian / EPOA (activated) agree to this referral?	☐ Yes	☐ No
Client requires dressing assistance?	☐ Yes	☐ No
Client requires showering assistance?	☐ Yes	☐ No
Client has mobility issues?	☐ Yes	☐ No
Cognition and/or decision making difficulties evident?	☐ Yes	☐ No
Lives alone?	☐ Yes	☐ No
Lack of informal support or carer stress present?	☐ Yes	☐ No
Has the client been discharged from hospital in the last six weeks?	☐ Yes	☐ No
Is this referral a result of an accident?	☐ Yes	☐ No
Is the client receiving Hospice services?	☐ Yes	☐ No

ACCESSIBILITY

If the client prefers an assessment / meeting in their own home, is this accessible i.e. no steps or stairs to access ☐ Yes ☐ No

FOR HOSPITAL ASSESSMENTS ONLY - SOCIAL WORKER TO COMPLETE

EPOA activated ☐ Yes ☐ No

EPOA holders name: _____ Phone number: _____

Address: _____

PLEASE INCLUDE EPOA DOCUMENTS AND ACTIVATION LETTER WITH REFERRAL

☐ Attached ☐ On patient's electronic health record

Cognition / decision making difficulties	☐ Yes	☐ No
Mental Health team involved	☐ Yes	☐ No
Nutritional concerns addressed	☐ Yes	☐ No
Occupational Therapy involvement completed	☐ Yes	☐ No
Physiotherapy involvement completed	☐ Yes	☐ No
Is the client under hospice care?	☐ Yes	☐ No
Is the client considered to be		
Approaching end of life (prognosis 3 weeks to 6months)	☐ Yes	☐ No
Last days of life (days to one week prognosis)	☐ Yes	☐ No
Imminently dying (hours prognosis)	☐ Yes	☐ No

SupportNet email: SupportNet.BOPDHB@bopdhb.govt.nz

PRINT FORM | OUTLOOK MUST BE OPEN when you click here to submit form | CLEAR FORM

Referrals that do not contain relevant information will be returned to referrer.