Phone: 06 353 5899
Fax: 06 353 5874

Supportlinks REFERRAL

Please complete referral in full to assist to determine eligibility for
Needs Assessment Service Coordination (NASC) Services.

Persons Details - Please complete a separate form for each person being referred:

Name: Mr/Mrs/Ms/Miss		**NHI:**
Address:		**DOB:**
		Phone:
Gender: Male/Female	**Ethnicity:**	**Email:**
Social Situation:	□ Living alone □ Living with others	**GP:**
Community Services Card No: 00000		**Expiry Date:**

Referrer Details:

Name:		**Date:**
Address:		**Phone:**
		Fax:
Relationship:		**Email:**

Consent for referral and disclosure of information provided by:

□ Person	□ Parent (child under 17)	□ Guardian	□ Additional Guardian	□ Welfare Guardian
□ EPOA Enacted □ Yes □ No	□ Other (Please describe)			
If consent is not provided by person or the parent of a child, documentation will be required to confirm who is legally able to consent on behalf of the person.				

Contact Details - Alternative Contact:

Name: Mr/Mrs/Ms/Miss		**Hm Phone:**
Address:		**Wk Phone:**
		Cell:
Relationship:		**Email:**

Is the person Eligible for Publicly Funded Health and Disability Services? □ Yes □ No

Disability Eligibility:

□ Intellectual	□ Physical	□ Sensory	□ Age Related

Other: – Including past history:

□ Personal Health	□ Mental Health	□ ACC Related	□ Palliative

Diagnosis: All diagnosis required & relevant information e.g. specialist reports

Please include a list of current medications with referrals

Reason for referral:

Please complete pages 1&2 for community referrals and all pages for hospital referrals.
For further information please refer to Information to Assist Completion of Referral to Supportlinks document (May 2010) or phone Supportlinks Customer Services on 06 353 5899.

August 2010

SUPPORTLINKS
Nga Kaupapa Hauā

Name: Mr/Mrs/Ms/Miss	**NHI:**

Functional Impairment (Likely to last 6 months or longer):

Safety Issues	Cognitive Impairment	Communication	Physical
□ 24 hr Supervision □ Falls Risk □ Medication	□ Memory □ Orientation □ Planning □ Initiation	□ Speech □ Hearing □ Social Isolation	□ Range of movement □ Mobility □ Swallowing □ Continence
Cognitive Assessment Completed & Results: MSE	EXIT	Other	
Intellectual Disability confirmed by psychological assessment? □ Yes □ No			
Comments:			

Functional Impairment Impacts on:

□ Personal care	□ Home Management	□ Carer Stress

Other Information: Please answer all questions.

Is the person in an acute phase of un-wellness?	□ Yes □ No
Have you considered short term services in the first instance?	□ Yes □ No
Does the person usually use a mobility aid? Type:	□ Yes □ No
Does the person already receive support through Supportlinks? □ Home based support □ Residential Services □ Carer Support	
Current informal support networks? □ Family □ Friends □ Neighbours □ Church □ None	
Is the person living with any other person receiving support through Supportlinks? Name:	□ Yes □ No
If cognitive impairment is indicated, and EPOA is not in place, has EPOA been discussed with the person and/or their family or this process commenced?	□ Yes □ No
Does the person being referred require a support person present at their assessment and/or assistance with communication? Name of the person and contact details:	□ Yes □ No
Does the person being referred have any cultural/religious requirements that Supportlinks should be aware of? Please describe:	

Other Specialist/Agency Involvement: Please indicate dates and provide relevant information.

Assessment or Specialised Input	Date	Outcome from involvement:
□ **Occupational Therapist:**		
□ **Physiotherapist:**		
□ **Speech Language Therapist:**		
□ **Psychologist:**		
□ **Social Worker:**		
□ **ElderHealth:**		
□ **Rehabilitation Unit:**		
□ **Child Development Unit:**		
□ **Child & Family Mental Health:**		
□ **Mental Health:**		
□ **Hospice:**		
□ **Special Education:**		
□ **Strengthening Families:**		
□ **Child, Youth & Family**		
□ **Community Field Officers:**		
□ **Other:**		

Name: Mr/Mrs/Ms/Miss	NHI:

Complete this page only if the person is in hospital

Reason for Hospital Admission:	Date of Admission:
	Ward:
	Likely Discharge Date:

In-Patient Discharge Plan	Comments:
Is there any further treatment planned? □ Yes □ No Have all rehabilitation options been explored? □ Yes □ No Have equipment solutions been explored? □ Yes □ No Are there natural support options available? □ Yes □ No Referral sent to Short term Home Help? □ Yes □ No Referral sent to Meals on Wheels? □ Yes □ No Referral sent to District Nurses? □ Yes □ No Referral sent to Palliative Care/Hospice? □ Yes □ No Person lives in another DHB area? □ Yes □ No Can be assessed post discharge at home? □ Yes □ No Unsafe to discharge prior to service coordination? □ Yes □ No Likely to require residential care? □ Yes □ No Previous hospital admissions in last 12 months? □ Yes □ No Please indicate dates: Other…..	

FOR SUPPORTLINKS STAFF ONLY

Phone Referral Taken by: Date:

Intake Team/Customer Services Coordinator to complete:

Eligible for DSS Services: □ Yes □ No □ Over 65/DHB □ Under 65/MOH

Deemed to be: □ MH □ PH □ ACC □ Other
□ IFP □ CMI
Decline details:

Recommendation: