## Referral for Outreach Clinic – Completed by EMS Assessor

# Wheelchair & Seating Outreach Service Referral & Outcome Summary

Wheelchair & Seating

Lying Supports/Positioning

**Type of clinic appointment** Choose an item **If In Person, please give rationale** Enter text

**Date of referral** Enter a date

**Preferred clinic date** Enter a date

**Preferred time** Enter text **Impossible times** Enter text

**Venue/address for clinic appointment** Enter text **Preferred method of contact:** Choose an item.

**Technician required?**  Yes  No

### Person’s Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name** | [Insert Family Name] | **First Name(s)** | [Insert First Name(s)] |
| **NHI** | [Insert NHI] | **Date of Birth** | Enter text |
| **Address** | Enter text | **Email** | Enter text |
| **Gender** | Choose an option | **Ethnicity** | Enter text |

### EMS Assessor Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Enter text | **AEA No.** | Enter text |
| **Phone** | Enter text | **Accreditation** | Choose an item |
| **Email** | Enter text | | |

### Eligibility Details

**Primary Diagnosis** Choose an item **Coexisting condition or other:** Enter text

**Resides:** Choose an item **If not listed, please state**: Enter text

**Funding Stream** Choose an item

### Explanation of Situation

**Background Information** (e.g., person’s social & living situation, roles, relevant history, services or supports)

Click or tap here to enter text.

**Current Functional Ability & Physical Findings** (e.g., person’s current equipment, range of motion)

Click or tap here to enter text.

**Current Issues/Challenges** (e.g., strengths, functional limitations/disability)

Click or tap here to enter text.

**Person’s Goals or Aspirations**

Click or tap here to enter text.

**Proposed Solution** (list your specific or preferred options if known)

Click or tap here to enter text.

### Include Attachments (where applicable)

|  |  |
| --- | --- |
| * Photos or video * Power wheelchair specification form * Manual specification form * Completed physical assessment form | * Confirmation of LTS-CHC funding * Evidence of main carer * Evidence of full-time tertiary study * Evidence of voluntary work * Evidence of full-time employment |

## Outcome of Consultation - Completed by Clinical Services Advisor, Outreach

### Appointment Details (e.g. clinic date, attendees etc)

Click or tap here to enter text.

### Goals

Click or tap here to enter text.

### Consultation Notes/Advice (e.g. new discussion points etc)

Click or tap here to enter text.

### Any Unmet Needs

Click or tap here to enter text.

### Outcomes and Recommendations (include equipment considered for trial)

Click or tap here to enter text.

### Plan (e.g. future actions, next steps, review etc)

Click or tap here to enter text.

Solution meets Whaikaha access criteria, consider proceeding to the EMS Portal

Solution does not meet Whaikaha access criteria, consider alternative solutions

Other: Enter text

**Date Completed** Enter a date

**Clinical Services Advisor** Choose an item

**Designation** Choose an item

Click on the icon below to paste in any photos

  

 