Community Health Referral Form

complexclinicalcarenetwork@wcdhb.health.nz

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Date_____

CLIENT DETAILS: NHI:..... Male ☐ Female ☐

Surname:..... First name..... Known as.....

DOB..... Phone:..... Mobile: .....

Address: (for service delivery):..... Post code: .....

GP: ..... Pharmacy: .....

Lives alone ☐ With spouse/partner ☐ With family ☐ Other ☐

NZ resident ☐ Yes ☐ No ☐ Unknown Ethnicity: .....

Next of Kin/carer/support person: Relationship: .....

Name: ..... Phone: .....

Address: ..... Mobile: .....

Language used: ☐ English ☐ Other: Please state: ..... Interpreter required ☐ Yes ☐ No

Is the client aware of this referral? ☐ Yes ☐ No Is the GP aware of the referral? ☐ Yes ☐ No

Is the referral the result of an accident? ☐ Yes ☐ No ACC Claim number: ..... Date of injury: .....

Is the client known to Mental Health? ☐ Yes ☐ No *(optional)*

YOUR ASSESSMENT: (Consider situation, background, **r**eason for referral, patient concerns/needs, identified risks)

Referral urgency: ☐ Urgent ☐ Semi urgent ☐ Routine

Currently in hospital ☐ Yes ☐ No: Date of admission: ...../...../..... Planned discharge date: ...../...../.....

Home visit safety risks present: ☐ Yes ☐ No: If yes, please state: .....

RELEVANT DIAGNOSES:

Mobility	**Cognition**		**Bowels**	**Skin integrity**	**Medication support**	**Dressing**
☐ Independent	☐ Intact		☐ Continent	☐ Intact	☐ Independent	☐ Independent
☐ Stick/ Crutches	☐ Some concerns		☐ Incontinent	☐ At risk	☐ Uses aids	☐ With supervision
☐ Frame	☐ Recent changes		**Bladder**	☐ Broken	☐ Prompting	☐ With assistance
☐ Wheelchair	☐ Known dementia		☐ Continent		☐ Dependent	**Bathing**
☐ Other:	**Vision**	**Hearing**	☐ Incontinent		**Nutrition**	☐ Independent
.....	☐ Good	☐ Good	**Recent grief /loss**	YES / NO	☐ Normal	☐ With supervision
.....	☐ Impaired	☐ Impaired	**Social isolation**	YES / NO	☐ Compromised	☐ With assistance

OTHER HEALTH PROFESSIONALS/SERVICES INVOLVED:

Referrer details:

Name: ..... Organisation: .....

Email: ..... Phone: .....

Signature: .....

PLEASE ATTACH ALL RELEVANT INFORMATION AND CLINICAL ASSESSMENTS TO THIS REFERRAL FORM