



# 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): _____
Residential address: _____		NHI No: _____
Email address: _____		Preferred name: _____
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: <input type="checkbox"/> Client <input type="checkbox"/> Contact person    Via: <input type="checkbox"/> Email <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client requires dressing assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client requires showering assistance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Client has mobility issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cognition and/or decision making difficulties evident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lives alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lack of informal support or carer stress present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the client been discharged from hospital in the last six weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this referral a result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the client receiving Hospice services?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health team involved	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nutritional concerns addressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational Therapy involvement completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physiotherapy involvement completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the client under hospice care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the client considered to be		
<b>Approaching end of life</b> (prognosis 3 weeks to 6months)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Last days of life</b> (days to one week prognosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Imminently dying</b> (hours prognosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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