



Capital and Coast Care Coordination Centre

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Urgent

Routine

Number of attached pages:

CLIENT DETAILS:

MSurname: First Names:..... NHI :

Known as: Dob : Male Female

Address (street, suburb, town):

..... Phone: [].....

GP: Phone: [].....

Lives: Alone With Spouse/Partner With Family Other:.....

N.Z. Resident: Yes No Unknown Ethnicity:

NOK/carer/support person:

Name: Phone:.....

Address..... Relationship:

Referrer:

Name: Of

Phone: Date Signature:

Is the client aware of this referral? Yes No Did the client agree to the referral? Yes No

Is the GP aware of this admission? Yes No Is the GP aware of this referral? Yes No

Is the client known to Mental Health Service? Yes No

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

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

DIAGNOSES::

REASON FOR REFERRAL and/or ADMISSION: (Include all relevant information)

Date of admission:/...../..... Anticipated d/c date:/...../..... Date service to commence:/...../.....

FAMILY, INFORMAL, OTHER SUPPORTS INVOLVED:

MOBILITY: <input type="checkbox"/> Independent <input type="checkbox"/> Stick <input type="checkbox"/> Crutches <input type="checkbox"/> Frame <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other.....	COGNITION: <input type="checkbox"/> Alert & rational <input type="checkbox"/> Mildly confused <input type="checkbox"/> Very confused	BOWELS: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent BLADDER <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent	HEARING: <input type="checkbox"/> Good <input type="checkbox"/> Impaired SKIN INTEGRITY: <input type="checkbox"/> Intact <input type="checkbox"/> Broken	SIGHT: <input type="checkbox"/> Good <input type="checkbox"/> Impaired NUTRITION: <input type="checkbox"/> Good <input type="checkbox"/> Compromised	ALERTS: <input type="checkbox"/> Infectious <input type="checkbox"/> Dog at home <input type="checkbox"/> Allergies <input type="checkbox"/> Safety risk <input type="checkbox"/> Other (Please state) Please give details
PLEASE ATTACH ALL RELEVANT INFORMATION AND CLINICAL ASSESSMENTS TO THIS REFERRAL FORM					