Capital Support Referral form

KENEPURU

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Surname: ..... NHI: .....
First Names: .....
Date of Birth: ...../...../..... Sex: .....
PLACE PATIENT ID HERE

WHEN COMPLETED, SEND TO:

Therapies, Kenepuru Hospital, PO Box 50215, Porirura 5240. Phone (04) 230 6400. Fax 04 918 2173.
Email: capitalsupport@ccdhb.org.nz

OFFICE USE ONLY		
Date received:	Entered:	Date/time first assessment:
☐ Routine		
☐ Urgent: please indicate immediate safety issue and reason for urgency		
Does the client currently receive services through Capital Support? ☐ Yes ☐ No ☐ Unsure		
If Yes, please provide information on page 3 as to why this referral is being made.		

PATIENT DETAILS				
Patient's preferred name:			Home:	
Mobile:			Email:	
Address:				
Community services card number:			Expiry date:	
Ethnicity:	☐ European/Pakeha		☐ Māori	☐ Pacific Island
	☐ Asian		☐ Other:	
NZ resident	☐ Yes	☐ No	☐ Unknown	
Communication method/language issues:				
Interpreter required:	☐ Yes	☐ No		
GP:			Phone:	
GP address:			Fax:	
Preferred assessor:	☐ Male	☐ Female	Ethnicity:	

MEDICAL DIAGNOSES AND DISABILITIES

List medical diagnosis:

For new referrals only: please note referrals can not be processed without a medical specialist's report that confirms the diagnosis.

For re-referrals: please use page 3 to identify why the new referral is being made.

LIST DISABILITIES GREATER THAN SIX MONTHS DURATION

Note: Short term, less than six months, disabilities refer to Care Coordination Centre for personal care/home help:

Please note eligibility is not met by a person's diagnosis alone. It is essential that the person's long term disability is also identified – this is only required for new referrals.

LIST ACC/ACCIDENT RELATED CONDITIONS

ACC claim registered	☐ Yes	☐ No	ACC services:

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NEXT OF KIN / CAREGIVER / CONTACT DETAILS			
☐ Next of kin	☐ Caregiver	☐ Contact	
Relationship to client:			
Full name (legal name) Mr/Ms/Mrs/Miss/Dr:			
Preferred name:		Phone:	
Address (street, suburb, town):			
Caregiver details:	NHI:	Date of birth: / /	☐ Male ☐ Female
Ethnicity	☐ European/Pakeha	☐ Māori	☐ Pacific Island
	☐ Asian	☐ Other:	
Communication Method/Language Issues:			
Interpreter required	☐ Yes	☐ No	

REFERRAL DETAILS			
Is the client aware of this referral? Yes No		Is the client in agreement to referral ☐ Yes ☐ No	
If client does not agree, please identify situation:			
Who consents for client if unable to (include legal status):			
Referrer's full name:		Designation:	
Phone:	Ext/page:	Fax:	Date: / /
Signed:		Email address:	
Reason for Referral:			
Referrals sent to other agencies (specify):			
History and background relevant to this referral:			
Current mental state / health / other concerns:			

OTHER HEALTH PROFESSIONAL / SUPPORT SERVICES INVOLVED AT THIS TIME			
☐ Home help	☐ Personal care	☐ Occupational Therapist	☐ IHC
☐ Child Development Team	☐ District Nurse	☐ Meals on Wheels	☐ Physiotherapist
☐ Social Worker - name:		☐ Other	

RISKS – PLEASE INDICATE POSSIBLE RISK FACTORS OR ALERTS THAT MAY NEED TO BE CONSIDERED

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Contd.

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For people who are already a client of capital support, please provide information to explain why a new referral is being made. This section can also be used to provide any relevant background or additional information.