Nurse Maude Care Coordination

Referral Form

Capital and Coast

CARE COORDINATION CENTRE

REFERRAL FOR COMMUNITY BASED HEALTH SERVICES AND HOME SUPPORT

To: Care Coordination Centre: 10 Wi-Neera Drive, PO Box 50 544, Porirua, 5240, New Zealand
Phone: (04) 238 2020 or 0800 282 200 Fax: (04) 238 2022 or 0800 282 202 Email: wellington@coordination.org.nz

☐ **Urgent** ☐ **Routine** **Number of attached pages: ……..**

CLIENT DETAILS:

M.....Surname:..... 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:	**COGNITION:**	**BOWELS:**	**HEARING:**	**SIGHT:**	**ALERTS:**
☐ Independent	☐ Alert & rational	☐ Continent	☐ Good	☐ Good	☐ Infectious
☐ Stick	☐ Mildly confused	☐ Incontinent	☐ Impaired	☐ Impaired	☐ Dog at home
☐ Crutches	☐ Very confused	**BLADDER**	**SKIN INTEGRITY:**	**NUTRITION:**	☐ Allergies
☐ Frame		☐ Continent	☐ Intact	☐ Good	☐ Safety risk
☐ Wheelchair		☐ Incontinent	☐ Broken	☐ Compromised	☐ Other (Please state)
☐ Other..... ……..	**PLEASE ATTACH ALL RELEVANT INFORMATION AND CLINICAL ASSESSMENTS TO THIS REFERRAL FORM**				……. **Please give details**