Te Whatu Ora
Health New Zealand
Waitematā

Older Adults & Home Health Services - Referral

Complete ALL sections and email to: olderadultshomehealth@waitematadhb.govt.nz

Patient Details:	NHI:
Given name/s:	DOB:
Surname:	Identifying gender: F M
Preferred name/s:	Other:

Patient's home address:

Contact phone number/s:

Visiting address *(if different from above)*:

Contact phone number/s *(if different from above)*:

Name and relationship to patient:

Consent to visit by patient: Yes No; *reason*:

Consent to visit by caregiver: Yes | **Name:** **Relationship:**
No; *reason:*

NZ Resident: Yes No	Ethnicity:	Interpreter: Yes No	Language:

Date of Referral:	ACC: Yes No	ACC No:

Community Services Card for home help: Yes No Don't know

Alerts: Yes; *specify:* No | **Allergies:** Yes; *specify:* No

Cancer Status: Ca Suspected Not relevant

Patient's home situation: Own home Retirement village Aged care facility
Other; *specify*: Lives with; *specify:*

Referrer Details:	☐ Self-referral
Name:	Designation:

Facility/practice name *(if applicable)*:

Contact phone:	Contact email:

Reason for referral:

Desired outcome:

Relevant medical information *(including any cognitive impairment/ falls etc)*:

Hearing impairment | Visual impairment | Housebound; why?

Current medications:

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Function	Able	Needs help	Comments
Mobility			Mobility aids used? Yes No | Type:
Hygiene; bathing / showering			
Dressing			
Toileting			
Taking medications			
Shopping			
Home help	☐		
Meal preparation			Nutrition/ Diet: Standard Modified Other; please specify:

District Nursing Referral

Please tick ✓service/s required and ensure **ALL** supporting documentation/information is provided with referral.
Note: Further information may be requested to assist referral decision.

Services required	REQUIRED supporting information/ documentation
Wound management	Attach wound care plan; wound photos *(if applicable).*
IDC/SPC cares	Type: | Duration: | Size: Supplies provided: Yes No | Education given: Yes No
Referral for TROC	Attach TROC plan: include date, acceptable post void residual (PVR) volumes and plan if TROC fails. IDC size: | Volume of water in balloon: mls
Outpatient IV Administration (OPIVA)	Attach *(as appropriate)*: – Authority to Administer Medication Chart for DN – PICC line insertion record – Authority to Remove PICC Line
Medication administration	Attach medication chart.
Gastrostomy/ nasogastric cares	Attach care plan. Size and type of feeding tube: | Supplies needed: Yes No
Ostomy management	Type of stoma: | Type/code of stoma appliance: Supplies provided: Yes No | Education given: Yes No Attach wound and stoma assessment including stoma outcome.
Continence management	Type: Duration: History/cause: Supplies provided: Yes No | Education given: Yes No Attach any investigations/ interventions taken; diagnostic results.
Palliative	Attached medication chart for syringe driver support. Equipment requested: Yes No | Supplies provided: Yes No
Drains and Tubes	Attach care plan. Types of drains/ tubes: | Supplies provided: Yes No
Other	

Patient Name: **NHI:**