

## Where are we based?

We have **two hubs**, one in **Greenlane** and one in **Point Chevalier**. The **team closest** to your **home** will **provide therapy** for you.

**East: Greenlane Clinical Centre.**

Phone reception: **09 631 1234**

**West:** 54 Carrington Road, Point Chevalier

Phone reception: **09 815 5628**

Your appointments can be at **home**, at the **outpatient clinic** or in the **community**.

We are **not** an **emergency service** so for **emergency medical needs** please **dial 111**.

### Non-smoking policy

Please **respect** ADHB's **non-smoking** policy by **not smoking** during **appointments**.

Welcome *Haere Mai*

## Comments, Compliments, Complaints

The **Auckland District Health Board** is **concerned** about the **quality of care** you **receive** and strives to maintain **high standards** of **healthcare**. However we do **appreciate** that there may be an **occasion** where **you**, or your **family/whanau**, feel **dissatisfied** with the standard of **service** you **receive**.

Please do **not hesitate** to **tell** us about your **concerns** as this **helps us** to learn from **your experience** and to **improve services** for future patients.

If you **feel** your **concerns** have **not been addressed** adequately you can **contact** the service **below**.

**Consumer Liaison, Building 7**

**Auckland City Hospital or email:**

**[feedback@adhb.govt.nz](mailto:feedback@adhb.govt.nz)**

| **Respect *Manaaki*** | Together *Tūhono* |



# Community Rehabilitation Service

## Information for Patients and their Whanau/Family



**Aim High *Angamua***

## Why have I been referred?

You have been **referred for rehabilitation** for your **health** condition. Rehabilitation aims to **maximise** the benefits of **recovery**, as well as **assisting** you to **compensate** for any persisting **difficulties**.

We will **work in partnership** with you and your **whanau/family** to:

- **Identify** what you want to do and **set goals**
- Find ways to help you to **achieve** your **goals**
- Develop an individualised **rehabilitation plan** to suit you and your **needs**
- **Develop** support **strategies** for you and your **whanau/family or care-giver**
- Regularly **review goals** to help you stay on target
- **Liaise** with other relevant **services** to **support** your health **needs** and **rehabilitation**

## The Community Rehabilitation Service

Our **team** of health **professionals** Includes:

- Clinical psychologist
- Dietitian
- Nurses
- Occupational therapists
- Physiotherapists
- Social worker
- Speech and language therapists
- Therapy assistants

A **member** of the **team** will be named as your **keyworker** and will act as a **contact** to guide you through your **rehab**.

Your **GP** continues to look after your **medical needs** including medication.

**Family** members and **support people** are welcome to **attend rehab sessions**.

## How long will I receive this service?

Generally you will be **seen** for between **four** and **twelve weeks**. This will depend on your **goals, needs** and **achievements**.

## What happens after my programme?

You will be **discharged** when:

- Your **goals** have been **achieved**
- You **no longer** feel you **require** our **services**
- Or when the **team** feels that **their input** is **no longer needed**

**You** and your **GP** will be **sent a letter** outlining your **involvement** with the **Community Rehabilitation Service**.

You may be **referred** on to **other services** should you need **long term support**.

If your **situation changes** in the future your **GP** can **refer you back** to the **Community Rehabilitation Service**.