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| PO Box 581  **Ashburton** 7740  DDI 03 2616907  **midcant@psusi.org.nz** | | PO Box 13-171  **Christchurch** 8141  DDI 03 261 2888  or 03 261 2890  **enliven@psusi.org.nz** | PO Box 665  **Rangiora** 7400  DDI 03 261 2888  or 03 261 2890  **enliven@psusi.org.nz** | | | 22 Alfred St  **Blenheim** 7201  DDI 032655214  **Nelson@psusi.org.nz** | | | PO Box 2411, Stoke  **Nelson** 7041  DDI 032655224  or 032655214  **Nelson@psusi.org.nz** | PO Box 536  **Greymouth** 7840  DDI 032645505  **hiedir@psusi.org.nz** |
| **Phone number for all regions 0800 477 874** | | | | | | | | | | |
| **Client details** | | | | | | | | | | |
| First name/s:       Preferred Name:  Last name: | | | | | | | | | NHI  D.O.B  Gender: | |
| Postal Address:  Town/City           Post Code: | | | | | | | | Phone:       Mobile:  Email: | | |
| Ethnicity: NZ Maori  NZ European  Pacific Island  Asian Other | | | | | | | | | | |
| **Living Situation**: Alone  Couple  With Family/Carer  Complex  Other: | | | | | | | | | | |
| **Support Person** :  Address  Relationship: | | | | | | | | | Phone:  Mobile:  Email: | |
| **Consent:** Client/Support person is aware of referral  Agrees to referral | | | | | | | | | **First Contact** Client  Support Person | |
| **G.P. Name:**             Practice / Address**:** | | | | | | | | | Phone:       Fax:  Email: | |
| **Referral Information required by all services** **Regional Single Point of Entry details above** | | | | | | | | | | |
| Referred by:  Referral Date: | | | Phone:  Email: | | | | | | **Covid 19 vaccination status**  **Vaccination pass sighted  Not vaccinated** | |
| **Enliven Services:** (Please tick required service/s and highlight location) | | | | | | | | | | |
| **Social Work:** Christchurch - Ashburton - Rangiora - Hurunui  **Counselling:** Ashburton, East Christchurch  **Falls Prevention:** Rangiora - Kaiapoi - Amberley  **Kaiāwhina**: Christchurch – North Canterbury  **Psychology:** East Christchurch  **Pastoral Care**: East Christchurch | | | | | | **Day Programmes:**  **For Enliven day programmes please send a request for funding to the DHB**  **Funding referral sent to DHB?**  **Yes** **No**  **Harakeke**  Riccarton - Linwood - Nelson  **Totara** Riccarton - Rangiora - Nelson - Marlborough  **HomeShare**  Ashburton - Selwyn - ChCh - Hurunui -  Rangiora - Marlborough - West Coast | | | | |
| **Reason for Referral:**  ( Social, Support Needs, Goals etc)  **Urgent**  **Routine** | | | | | | | | | | |
|  | | | | | | | | | | |
| Specific needs/general comment | | | | | | | | | | |
| **Current Services and Provider details:** | | | | | Subsidies Approved: Day care  Carer Support | | | | | |
| Social Worker / Key Worker: | | | | | Day Care : No. of days     .wk Review due: | | | | | |
| Home Care Provider | | | | | Carer Support: No. of days allocated | | | | | |
| Other: | | | | Community Service Card: **Yes**  **No**  Mobility Card:  **Yes**  **No** | | | | | | |
| Disability Allowance: **Yes** **No** Requires Application Form | | | | | | |
| Service Specific Information please complete relevant to required service needs | | | | | | | | | | |
| **Risk Factors**:  Falls  Allergies Mood/emotional status Nutrition  Environment  Other  Details: | | | | | | | | | | |
| **Cognition / Dementia:**  **Dementia Diagnosed**  Yes  No  Dementia Type (if known)  **Memory Loss**: Mild  Moderate  Severe  **Level of functioning:**    **Behavioural concerns:** | | | | | | | | | | |
| **Sensory and mobility** ( √ ) Comments: | | | | | | | | | | |
| **Sight**    **Hearing**    **Mobility**  **Toileting** | Good  Impaired Spectacles  Good  Impaired  Wears aids  Independent  Assistance  Mobility Aids    Independent  Reminders  Assistance | | | | | |  | | | |
| **Specialist / Support Services involved**: (please indicate name and contact details | | | | | | | | | | |
| **Health issues: Include:** Diagnoses/ Concerns/ Medication | | | | | | | | | | |
| **Additional information** specific to the service referred to e.g. EPoA, Medical alarm, Protection Order, Home and Family. | | | | | | | | | | |
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| ***Office Use Only:***  Preferred attend days: M T W  Th  F S  Preferred attend times:  Account sent to (if applicable): | | | | | | Referral acknowledgment date:  Triage Date:  Date allocated/cancelled:  Allocated to: | | | | |