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| PO Box 581**Ashburton** 7740DDI 03 2616907**midcant@psusi.org.nz** | PO Box 13-171**Christchurch** 8141DDI 03 261 2888or 03 261 2890**enliven@psusi.org.nz** | PO Box 665**Rangiora** 7400DDI 03 261 2888or 03 261 2890**enliven@psusi.org.nz** | 22 Alfred St**Blenheim** 7201DDI 032655214**Nelson@psusi.org.nz** | PO Box 2411, Stoke**Nelson** 7041DDI 032655224or 032655214**Nelson@psusi.org.nz** | PO Box 536**Greymouth** 7840DDI 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.      |
|       |
| ***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:      |