Care Coordination Referral Form

Capital and Coast
Email: wellington@careco.org.nz
Phone: (04) 566 2226 or 0800 662 225

Hutt Valley
Email: hutt@careco.org.nz
Phone: (04) 238 2020 or 0800282200

CLIENT DETAILS:
Mr/Mrs Surname: First Names NHI:
Known As: DoB Male ☐ Female ☐ Other ☐
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: Email:
Address: Phone:
Relationship:

Referrer: Name:. Of
Phone: Email:
Date: Signature: Phone:

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 client known to Whaikaha (Disability) NASC Yes No
Language used: ☐ English ☐ Other: Please state: Interpreter required: ☐ Yes ☐ No

DIAGNOSES (current / relevant to referral):

REASON FOR REFERRAL: (Include all relevant information, including current care challenges)

Date of admission: ………../………./………. Anticipated d/c date: ………../………./………. Date service to commence: ………../………./……

OTHER SUPPORTS INVOLVED (formal and informal / family):

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 PROVIDE RELEVANT INFORMATION / DOCUMENTS AND CLINICAL ASSESSMENTS WITH THIS REFERRAL FORM**				…………………………… **Please give details**