Received by……Time……Date…….
Discussed with:……Time……Date…….
Response by:……Time……Date…….

Adult Crisis/Urgent Respite Referral Form

Person's name:			**Legal Status:**	
DOB:	dd/mm/yyyy		**NHI:**	
Gender:	**Male**	**Female**	**Other/Non Binary**	**Ethnicity:**
Address:				
Phone (Landline):			**Phone (cell):**	
Emergency Contact details:				

For GPs only:- Referrer Name:	**Phone:**
Fax:-	

Is the person currently under Specialist psychiatric care? Y / N

For SMHS only:- Referrer Name:	**Phone:**
Regular Case Manager (if different from referrer):	
Sector/Specialist Team:	

DIAGNOSIS: (Mental Health):			
(Physical):			
Proposed Length of stay (Max 3 days) – Please ✓	**1 day**	**2 days**	**3 days**
Reason and goals for respite:			

What is the plan on completion of respite? –Please ✓	**(GPs only) – Funded visit within 72hrs**	**Home**	**Care by relative**	**Other – Please detail:**

Support Plan: Does the person require specific support with (or monitoring) in any of the following areas? If any are required – please specify required actions where appropriate.

☐	**Sleep Pattern:**
☐	**Eating/drinking:**
☐	**Smoking cessation:**
☐	**Physical Needs (eg special diet, access/mobility reqts):**
☐	**Safety/self-harm:**
☐	**Mood:**
☐	**Other:**

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Medication Support:-
Referrals must include a print-out of current MH and Physical medications (including PRN)

1. **Does the person require support with medications?** **YES / NO**
2. **Comments:-**
3. **Does the person have any medication, or other significant, allergies?:-**
4. **Are any controlled drugs prescribed?** **YES / NO**

Risk Factors: (If YES – please specify)

Potential Risk	Y/N	Comments	Required Interventions
Person does not arrive for respite?			☐ Contact client ☐ Contact emergency contact number ☐ Contact GP (via 24hr surgery) ☐ Contact Referrer
Able to leave respite unaccompanied? (during respite and/or on discharge?)			
History of self-harm / attempted suicide?			
Current risk to others or recent violence?			
History of alcohol/drug abuse?			
Other risks we should be aware of?			

For GPs only:
1. **Within GP working hours – the GP retains clinical responsibility for the person.**
2. **Out of hours – worsening psychiatric symptoms - If the person has worsening psychiatric symptoms, do you wish –**

☐ **To take clinical oversight and be phoned at an after-hours number?**
Please provide number:-……

☐ **For the person to be taken to Bealey Avenue 24-hour surgery for review and management (no cost to person)**

3. **Out of hours – psychiatric emergency – If the Respite Provider feels that the person presents significant risk to self or others, the Provider will contact the Crisis Resolution Team in Specialist Mental Health Service for a risk assessment.**

Required documents:-	GP	SMHS
Medication – print-out of current medications including PRN	✓	✓
Reviewed and updated Risk Management Plan:	If available	✓
Most recent assessment or case note:	x	✓

(Please print name & sign)

Referrer _____ **Time & Date** _____

Send completed form to:

PATHWAYS

Fax: (03) 339 0549 - Tel: (03) 339 0574

E: respite.southern@pathways.co.nz

stepping stone trust
Te Roopu o te Taumata Kohatu

Fax- (03) 338 8842 – Tel: (03) 338 8803

E: arespite@stepstone.org.nz