

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	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
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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:			

<p>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.</p> <p><input type="checkbox"/> Sleep Pattern:</p> <p><input type="checkbox"/> Eating/drinking:</p> <p><input type="checkbox"/> Smoking cessation:</p> <p><input type="checkbox"/> Physical Needs (eg special diet, access/mobility reqts):</p> <p><input type="checkbox"/> Safety/self-harm:</p> <p><input type="checkbox"/> Mood:</p> <p><input type="checkbox"/> Other:</p>
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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?:-

Risk Factors: (If YES – please specify)

<u>Potential Risk</u>	<u>Y/N</u>	<u>Comments</u>	<u>Required Interventions</u>
Person does not arrive for respite?			<input type="checkbox"/> Contact client <input type="checkbox"/> Contact emergency contact number <input type="checkbox"/> Contact GP (via 24hr surgery) <input type="checkbox"/> 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:-

	<u>GP</u>	<u>SMHS</u>
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

Fax- (03) 338 8842 – Tel: (03) 338 8803
 E: arespite@stepstone.org.nz