Waikato District Health Board

Older Persons and Rehabilitation

Single point of entry referral form

Patient Label

Name: _____

NHI: _____ DOB: _____ dd/mm/yy

Address: _____

Email referral to rcc@waikatodhb.health.nz

Gender – ☐ Male ☐ Female

Phone _____ Mobile _____

Ethnicity _____

GP name _____

Alerts / allergies:

Has the patient got an infectious disease? ☐ Yes ☐ No

If yes, ☐ MRSA ☐ ESBL ☐ C. Diff ☐ V. RE ☐ Hep B

Preferred contact:

Name _____

Address _____

_____

Relationship _____

Phone – Day _____

– Mobile _____

Patient consents to referral? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No Language _____

ACC number (if relevant) _____

Date of injury (for ACC) _____

Community Service Card (if requesting NASC) ☐ Yes ☐ No

Number _____ Exp _____

Does the client have cognitive impairment? ☐ Yes ☐ No

Does the client have a neurological condition? ☐ Yes ☐ No

Does the client have brittle social support system? ☐ Yes ☐ No

Does the client require medication management? ☐ Yes ☐ No

Does the client need assistance to dress? ☐ Yes ☐ No

Does the client prefer a Māori assessor? ☐ Yes ☐ No

Situation

Diagnosis

Background

Reason for referral / relevant medical Hx

Assessment

Current health information and functional status ***(mobility, assistance required, pain level, falls history, continence, nutrition, wounds, pressure injuries, previous level of functioning in last 90 days, social history)***

Does the client have communication or hearing issues? ☐ Yes ☐ No ***If yes, describe:***

Recommendation

Please indicate which service is appropriate:

☐ Inpatient / rehabilitation ☐ Thames rehab ☐ Convalescent care *(Rhoda Read or Matariki)*

☐ OPR Outpatient Clinic ☐ START ☐ NASC/DSL

☐ Geriatrician advice review ☐ CNS Gerontology ☐ R & R

Referrer name _____ Signature _____

Designation _____ Date _____ dd/mm/yy Time _____ 24 hour Contact number _____

Referral source

☐ GP ☐ Self ☐ Community provider ☐ DSL/NASC ☐ Private hospital

☐ Waikato ward ☐ Outpatient clinic ☐ District hospitals (non Waikato)