COUNTIES MANUKAU HEALTH

Reablement and Short Term Home Based Supports Referral

Referring For

Reablement

- ☐ Potential to improve function / independence
- ☐ Supported Discharge (*monitoring patient progress post hospital admission*)
- ☐ Early Supported Discharge (*transitioning from hospital early & medically safe for discharge*)

Short Term Home Based Supports

- ☐ 2-6 Weeks Home Based Supports
- ☐ 12 Weeks Home Based Supports for palliative

Are other referrals being generated as a result of this admission?

Please advise as applicable

SUPPORT NEEDS

Goal Hospital Discharge Date:

Date of Referral:

When are supports required following discharge: ☐ Urgent / Same Day ☐ Within 24-48 hours ☐ Within 2-3 days ☐ Other

Enter other information here if choice is not available

Describe immediate Support needs during the first 48 hours post discharge:

PATIENT DETAILS

NHI:

Patient Last Name:

Patient First Name:

Date of Birth:

Visiting Address:

Contact Phone Numbers:

Gender: ☐ Male ☐ Female

Ethnicity: ☐ European ☐ Pacific ☐ Maori ☐ Asian ☐ Other

Enter enthnicity here if choice not available

Language Barriers?

NOK Details:
Name, relationship and contact details

GP Name:

GP Phone:

SAFETY ISSUES

Are there any known safety issues for visiting staff? ☐ Yes ☐ No

Are their any known issues with Personal / Family behaviour at this address? ☐ Yes ☐ No

Is there a dog at the house? ☐ Yes ☐ No

If YES, has the patient been advised to tie the dog up on the day of the visit? ☐ Yes ☐ No

Please advise of any other Alerts or Safety concerns:

REFERRER DETAILS

Name of Referrer:
First and Last Name

Referrer Email Address

Designation of Referrer:

☐ Nursing ☐ Social Worker ☐ Occupational Therapist ☐ APAC Nurse
☐ Charge Nurse Manager ☐ Reablement Locality Coordinator ☐ Physiotherapist
☐ Doctor ☐ NASC ☐ Other (please indicate below)

Enter designation here if choice not available

Referring Ward or Location:

Other: please indicate if not listed above

Hospital Contact Clinician and Role:

TRANSITION PATHWAY SCREENING

Has the individual had a functional decline as a result of a recent illness or injury? ☐ Yes ☐ No

Will the individual have potential for functional improvement within 2-6 weeks? ☐ Yes ☐ No

Does the individual have a prescribed physical restriction for a defined period? ☐ Yes ☐ No **if YES patient may be suitable for Reablement pathway**

Please explain

e.g. non-weight bearing for 6 weeks post surgery

MEDICAL HISTORY

Active medical problems / Reason for Hospital Admission

Level of Cognition:

PRE-MORBID FUNCTION	CURRENT DEFECIT
☐ Alert	☐ Alert
☐ Mild confusion	☐ Mild confusion
☐ Very confused	☐ Very confused
☐ Wanders	☐ Wanders
☐ Known dementia	☐ Known dementia
☐ Recent delirium	☐ Recent delirium

Enter OTHER Level of Cognition here if choice not available

Mobility:

PRE-MORBID FUNCTION	CURRENT DEFECIT
☐ Falls risk	☐ Falls risk
☐ Independent	☐ Independent
☐ Walking frame	☐ Walking frame
☐ Assistance	☐ Assistance
☐ Bed bound	☐ Bed bound

Enter OTHER Mobility here if choice not available

Does the patient have rental equipment that requires follow up ☐ Yes ☐ No

Continence:

PRE-MORBID FUNCTION	CURRENT DEFECIT
☐ Fully continent	☐ Fully continent
☐ Bladder incontinence	☐ Bladder incontinence
☐ Bowel incontinence	☐ Bowel incontinence
☐ Catheter	☐ Catheter
☐ Stoma	☐ Stoma
☐ No known issues	☐ No known issues

Enter OTHER Continence here if choice not available

Areas where patient requires assistance with self cares / mobility etc.

PRE-MORBID FUNCTION	CURRENT DEFECIT
☐ Taking medications	☐ Taking medications
☐ Bathing / Showering	☐ Bathing / Showering
☐ Dressing	☐ Dressing
☐ Toileting	☐ Toileting
☐ Mobilising	☐ Mobilising
☐ Getting out of bed	☐ Getting out of bed
☐ Feeding	☐ Feeding
☐ Houshold tasks (cleaning)	☐ Houshold tasks (cleaning)
☐ Shopping	☐ Shopping

Enter OTHER Information here if choice not available

Advanced personal cares:

- ☐ Stoma
- ☐ Feeding Tube
- ☐ Catheter
- ☐ Palliative Cares

Details as required:

Patient goals:

Is the Patient already known to NASC? ☐ Yes ☐ No ☐ Do Not Know

Does the patient currently have personal cares of household management?

Does the Patient live alone? ☐ Lives Alone ☐ Lives with Family ☐ Other (please define below)

Enter Other information here if choice not available

Is this patient the main caregiver for someone else in the home? ☐ Yes ☐ No

SERVICE PROVIDER

Has the patient been asked if they have a preferred provider? ☐ Yes ☐ No

Patient's preferred provider: **(if applicable)**

- ☐ Not Applicable
- ☐ Access Home Health ☐ Counties Manukau Homecare ☐ Healthvision ☐ Healthcare of NZ

REABLEMENT ONLY

Reablement referral has been documented in the medical notes and discharge summary? ☐ Yes ☐ No

Patient provided with reablement brochure? ☐ Yes ☐ No

Has patient agreed to use Short Term Provider for Reablement? ☐ Yes ☐ No

Has the patient consented to their information being communicated via Shared Care? ☐ Yes ☐ No