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| Community Nursing Referral Form | | | | |
| For use by community-based providers. We can also accept referrals via ERMS | | | | |
| **To** | Laura Fergusson Brain Injury Trust (Assessment Services) | | **Date** |  |
| **Contact** | Phone (03) 335 0541 | Email hello@lfbit.co.nz | | |

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| Kiritaki (client) details | | | | |
| Client’s name |  | | | |
| Date of birth |  | | NHI |  |
| Address |  | | | |
|  | | | |
| Contact phone Number(s) |  | | | |
| Email address (if known) |  | | | |
| Ethnicity | NZ European/Pakeha | | NZ Māori | |
| Asian | | Pacific Islander | |
| Other (please specify) | | | |
| Is an interpreter required? | Yes  No | Which language? | | |
| Is there any other support required? | Yes  No | Please describe | | |
|  | | |

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| **Reason for referral** | |
| **Please describe type of service required** (e.g. pressure area or wound assessment) | |
|  | |
| **Please indicate as appropriate** | |
|  | The injury is too complex to be managed by the client’s general practice team (e.g. pressure wound, prior history of complex wounds, client is immuno-compromised, compression therapy, stoma care) |
| ☐ | The client is physically unable or unsafe to travel to GP (e.g. reduced mobility, insufficient natural/social support to access GP, no public transport available) |
| ☐ | The client requires treatment outside the usual operating hours of their GP practice |
| ☐ | The client is not enrolled with a GP or is unable to enrol with a GP. |
| ☐ | Client lives in a rural area more than 50km or 30 minutes’ drive from the nearest medical centre or emergency department |

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| **Background** | | | |
| Date of injury/incident |  | ACC45/ACC Claim No. |  |
| Brief description of accident |  | | |
| Brief description of injuries and/or current condition |  | | |
| Medical notes and Reports attached | | | |

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| **Additional information** |
| (e.g. relevant background medical information/health conditions, Key Support people, other health professionals involved, court orders in place) |
|  |
| **Other** |
| Is there anything that we should be aware of if we visit the client’s home (e.g. cultural/spiritual considerations, dogs, steep driveways/stairs, parking access, other visitors to the home)? Please detail below |
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| **Referrer Details** | | |
| Provider name and organisation | |  |
| Contact phone number | |  |
| Email address (if appropriate) | |  |
| Signed |  | |