|  |
| --- |
| 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 |

|  |
| --- |
| 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 |
|  |

|  |
| --- |
| **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 |

|  |
| --- |
| **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 |

|  |
| --- |
| **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 |
|  |

|  |
| --- |
| **Referrer Details** |
| Provider name and organisation  |  |
| Contact phone number |  |
| Email address (if appropriate) |  |
| Signed |  |