Adult Crisis/Urgent Respite Referral Form

|  |  |  |
| --- | --- | --- |
| **Person’s name:** |  | **Legal Status:** |
| **DOB: dd/mm/yyyy** |  | **NHI:** |
| **Gender: Male** | **Female** | **Other/Non Binary 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** |

|  |
| --- |
| **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:** |

|  |
| --- |
| **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.** |
|  **Sleep Pattern:** |
|  **Eating/drinking:** |
|  **Smoking cessation:** |
|  **Physical Needs (eg special diet, access/mobility reqts):** |
|  **Safety/self-harm:** |
|  **Mood:** |
|  **Other:** |

|  |
| --- |
| **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:-**
 |
| 1. **Does the person have any medication, or other significant, allergies?:-**
2. **Are any controlled drugs prescribed? YES / NO**
 |

|  |
| --- |
| **Risk Factors: (If YES – please specify)** |
| **Potential Risk** | **Y/N** | **Comments** | **Required Interventions** |
| **Person does not arrive for respite?** |  |  | * Contact client
* Contact emergency contact number
* Contact GP (via 24hr surgery)
* 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:-** | **GP** | **SMHS** |
| **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:**

 

**Tel: (03) 339 0574 Tel: (03) 338 8803 M: 022 583 6011**

**E:** **respite.southern@pathways.co.nz** **E:** **arespite@stepstone.org.nz**