

**Adult Wellness** *(Planned)* **Respite Allocation Form**

*This form has a use by date of one calendar year and must be completed and resent by the referrer on an annual basis*

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| Person’s name: Todays Date: |
| DOB: dd/mm/yyyy NHI: |
| Gender: Male Female Other / Non-binary |
| Ethnicity: |
| Address: |
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| Phone: Phone (cell): |
| Email Address: |
| Preferred method of contact: |
| Contact Person - details: [name / relationship to patient / phone number] |

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| **For GPs only:-**  **Referrer Name:**  **Name of medical practice:**  **Phone: Email:** |

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| For SMHS only:-  Referrer Name: |
| Regular Case Manager (if different from referrer): |
| Sector/Specialist Team:  Phone: Email: |

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| DIAGNOSIS: (Mental Health): |
| (Physical): |

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| ALLOCATION: - It is recommended the usual allocation of planned respite days *per 12 month period* be  10 – 14 days, with a maximum of 28 days. | |
| No. of days allocated: - | **For year beginning: - dd/mm/yyyy** |
| Goals for respite: | |

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| 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 (e.g. special diet, access/mobility requests, allergies): |
| 🞏 Safety/self-harm: |
| 🞏 Mood: |
| 🞏 Other: |

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| **Medication**  The person that you are referring must bring their own medication to each Wellness Respite stay and be competent and safe to administer their own medications from the locked safe in their own bedroom for the duration of their stay.  *We require the referrer to advise the competency of the person referred to administer their own medication. If the person is not competent to administer their own medication while at Wellness Respite, then the referrer will need to consider if they can arrange for other services/supports to administer the medication for the person while at Wellness Respite service.*  **Referrer GP/Case Manager**  It is my opinion that the above person referred to Wellness Respite is competent to administer their own medication during their stays at Wellness Respite.  🞏 **YES**  🞏 **NO**  Name: Date:  Sign:  *The person referred must bring with them a current list of their medications for each Respite stay.* |

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| Risk Factors: If YES – please specify  Please be aware that the Stepping Stone Wellness Respite site is not staffed overnight and is on an elevated hill site with stairs. | | | |
| Potential Risk | **Y/N** | **Comments** |  |
| History of self-harm / attempted suicide? |  |  |  |
| History of alcohol/drug abuse? |  |  |  |
| History of fire setting? |  |  |  |
| History of violence? |  |  |  |
| Other risks we should be aware of including:  Physical/mobility issues  Fall risk |  |  |  |

**Send completed form to:** [**arespite2@stepstone.org.nz**](mailto:arespite2@stepstone.org.nz)

**Tel: (03) 339 6120**

